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**Barriers to engagement with assisted bibliotherapy
in primary care**

To Ian

Go get 'em, Champ

Overview

Volume 1 of this thesis is presented in three parts. Part 1 is a review of outcome studies on text-based guided self-help for depression and anxiety in primary care, specifically focusing on satisfaction, adherence and attrition. Part 2 is a qualitative interview study examining the views and experiences of 13 people (plus two more who gave details via email) who attended a guided self-help service and did not engage or did not benefit. Part 3 is a critical appraisal of the research process, which considers some of the conceptual and methodological issues encountered, before concluding with a discussion of personal reflections on the impact of the research on the participants and researcher.

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Part 1: Literature review

Attrition, adherence and satisfaction in outcome studies of assisted bibliotherapy for anxiety and depression in primary care

Abstract

Background: Guided self-help is increasingly being adopted as a cost-effective way to increase the availability of effective psychological therapies, such as cognitive behavior therapy, for the treatment of depression and anxiety in primary care. Previous reviews in this area have focused on efficacy and effectiveness, but there is little evidence systematically examining the reporting of attrition in outcome studies and how it relates to satisfaction with and adherence to self-help materials.

Aims: This review aims to explore the relationship between adherence, attrition and satisfaction in outcome research on text-based guided self-help, or 'assisted bibliotherapy' within a primary care community setting, and draw together potential evidence that may inform efforts to improve services.

Method: To be included, studies had to satisfy criteria relating to: i) nature of the intervention, ii) target problems, iii) outcome measures, iv) setting, and v) research design. Fifteen studies were identified from four electronic databases (CINAHL Plus, Embase, Medline and Psycinfo), references of previous reviews and from relevant authors in the field.

Results: Satisfaction was generally high and adherence was at least adequate, and in many cases good. However, attrition was a common problem, particularly at follow-up, and several points make it difficult to draw conclusions from the studies reviewed: the design quality and reporting of results was variable, inadequate detail was often given about attrition, adherence and satisfaction were not consistently explored, and rarely were the possible links between these factors explicitly considered.

Conclusions: More detailed reporting of attrition, adherence and satisfaction is required in high-quality outcome research on assisted bibliotherapy in order to evaluate the factors contributing to engagement and disengagement.

Introduction

Depression and anxiety are common and often paralysing conditions that have far reaching implications on both an individual and a societal level, and it is estimated that by 2020 depression will be the leading disease burden worldwide (World Health Organization, 2001). These difficulties are a feature of approximately a quarter of GP consultations (Department of Health, 2000), but primary care services do not have the resources to cope (Farrand, Confue, Byng & Shaw, 2008).

Psychological therapies have consistently been demonstrated to be effective in treating anxiety and depression, and Cognitive Behaviour Therapy (CBT) is recommended as a treatment of choice within primary care (NICE, 2011), as it has the most convincing empirical support (NICE, 2004a,b). Nonetheless, due to the a of appropriately trained and experienced mental health professionals (Bower & Gilbody, 2005) and the resultant lengthy waiting lists (Lovell, Richards & Bower, 2003), access to such evidence-based treatment is varied, and in many cases it is unavailable (Lovell & Richards, 2000).

Self-help materials, such as books, videos and computer programmes, are increasingly being adopted as a cost-effective way to increase the availability of psychological therapies such as CBT, with a surge in use and research over the past decade. These 'health technologies' are designed to provide patients with the skills and confidence to manage symptoms or challenging situations without significant input from professionals (Gellataly, Bower, Hennessey, Richards & Lovell, 2007). The growing body of evidence from review studies suggests that such methods are effective in reducing the distress and interference associated with common mental health problems (Bower, Richards & Lovell, 2001; Den Boer, Wiersama & Van Den Bosch, 2004), and in some cases, effectiveness is equivalent to traditional therapist-directed interventions (Cuijpers, Donker, Van Straten & Andersson, 2010).

A recent review indicated that self-help materials are considerably more effective when they are accompanied by support from professionals or paraprofessionals (practitioners without specialised training in formal psychological therapy) (Gellatly et al., 2007). However, despite the demonstrated effectiveness of such 'guided' self-help, clients commonly report ambivalence towards this kind of intervention in primary care (Khan, Bower & Rogers, 2007).

Bower et al. (2005) suggested that the acceptability of minimal interventions such as guided self-help is crucial for effective implementation. According to Priest, Vize, Roberts, Roberts and Tylee (1996), patient attitudes towards psychological therapies are generally positive but Scogin, Hanson and Welsh (2003) warned that minimal interventions, such as guided self-help, may be viewed as inappropriate or inadequate. This hypothesis could account for the low uptake of such interventions observed in a recent review (Waller & Gilbody, 2009). For example, Whitfield, Williams and Shapiro (2001) reported that only approximately half of the people on a waiting list for CBT took up the offer of self-help despite there being no detrimental effect on their place on the waiting list or their chances of receiving therapy if they accepted. Similarly, poor adherence and high attrition have been observed in numerous studies on guided self-help; for example, Banasiak, Paxton and Hay (2007) outline a number of studies relating to eating disorders, some with attrition rates as high as 70%. It is clear that more needs to be known about the factors related to engagement with and benefit from guided self-help, such as satisfaction and adherence, to ensure that resources are directed at people who are most likely to gain from them and to tailor interventions so that maximal benefit can be obtained.

This is particularly pertinent when considering the introduction of the Increasing Access to Psychological Therapies (IAPT) programme, put forward by the Department of Health in 2007. This multi-million pound endeavour has placed guided self-help firmly

on the political and economic map, and is intended to address the discrepancy between those in need and the services available to them by expanding the evidence-based psychological therapy provision on an unprecedented scale. The profound investment is predicted to alleviate distress, promote understanding of mental illness and support people in the workplace or hoping to return to work (Turpin, Richards, Hope & Duffy, 2008). It follows the 'stepped care' model (Haaga, 2000), increasing therapeutic input according to need, and features high- and low-intensity interventions based on CBT principles. Low-intensity treatments, including guided self-help, emphasise self-management with brief contact from paraprofessionals, whereas high intensity interventions mirror traditional therapy models and involve greater input from a qualified clinician.

The evidence supporting the expansion of low-intensity services at the heart of the IAPT programme is growing. Bower and Rowland (2006) rated effectiveness of guided self-help as similar to primary care counselling sessions, which required significantly more therapy hours. Furthermore, Farrand et al. (2008) describe a number of studies documenting the successful role of Graduate Mental Health Workers (GMHWs), who are in greater supply and significantly more cost-effective than mental health professionals with more formal training. At the time of writing, the IAPT programme is in its infancy, but in spite of this expanding evidence-base, there are concerns about the effect of implementing such a large scale programme, with the reception to the proposals ranging from 'warm, through tepid to icy cold' (Richard & Suckling, 2008). Given the magnitude of the investment and the importance of its success, for patients as well as the profession, research into establishing and understanding the factors involved in disengagement and lack of benefit is vital in order to tailor services and ensure that the investment is not squandered.

As well as examining effectiveness, it is important to consider perceptions of credibility and satisfaction with low-intensity CBT interventions, as these factors are likely to have an effect on adherence to materials and implementation of advice from the worker. Poor adherence is unlikely to lead to clinical improvement, and Ritterband, Thondike Vasquez and Saylor (2010) argued that better understanding of treatment credibility and user satisfaction is important for shaping future interventions, informing practitioners about how best to educate patients and influence expectations for treatment. They give the example of setting positive pre-treatment expectations of treatment credibility and user satisfaction which could attenuate treatment dropout and lead to improved treatment outcomes.

Previous reviews

There have been several prior reviews in the self-help and guided self-help arena and, generally, the main aim has been to examine effectiveness (see Table 1). Consideration of satisfaction, attrition and adherence has not taken priority. Some reviews have compared a range of interventions including computer- or internet-based programmes, video/ audio recordings and self-help groups (Cuijpers et al., 2010; Hirai & Clum, 2006). Others have concentrated exclusively on one specific type of intervention, for example, bibliotherapy (Anderson et al., 2005; Van Boeijen et al., 2005), or on unguided interventions (Morgan & Form, 2008). The scope of previous reviews has also varied in relation to the target problem, as some have included a wide range of clinical problems (Bower et al., 2001; Den Boer et al., 2004), while others have focused on one particular clinical presentation, such as anxiety (Hirai et al., 2006) or depression (Khan et al., 2007).

The review most thematically related to the present one is that of Khan et al. (2007), who presented a meta-synthesis of qualitative studies looking at patient experience, exploring help-seeking, ambivalence, stigma and personal agency.

Table 1: Characteristics of previous reviews

Review	Focus and type of problem	Method of review	Description of intervention	Main difference from current review
Bower et al. (2001)	Self-help for anxiety and depression in primary care	Systematic review	Self-help delivered through text, audiotape, videotape, group meetings or individual exercises such as 'therapeutic writing'	Intervention predominantly independent self-help; focus on clinical and cost-effectiveness
Lewis et al. (2003)	Self-help interventions for mental health problems	Systematic review	Self-help including books, CD-ROMs, self-help groups, etc.	Intervention predominantly independent self-help; focus on broad range of self-help materials
Den Boer et al. (2004)	Self-help for emotional disorders	Meta-analysis	Bibliotherapy with regular phone contact and groups	Focus on examination of <i>effectiveness</i> of self-help bibliotherapy and groups
Anderson et al. (2005)	Self-help books for depression	Systematic review	Written material used with minimal guidance	Focus is on studies evaluating the merits of specific books/ materials available to the public
Van Boeijen et al. (2005)	Self-help manuals for anxiety in primary care	Systematic review	Booklets or manuals designed to be used with minimal contact with a professional	Specific focus on efficacy; restricted to anxiety
Bower et al. (2005)	Stepped care in psychological therapies	Narrative literature review	N/A – consideration of access, effectiveness and efficiency	Consideration of clinical and economic considerations involved in stepped care
Hirai et al. (2006)	Self-help for anxiety	Meta- analysis	A variety of self-help media; differing formats of minimal contact	Quantitative analysis; review of effectiveness for a broad span of self-help approaches; anxiety only
Gellatly et al. (2007)	Self-help for depression	Meta-analysis and meta-regression	Self-help delivered through text, audiotape, videotape, group meetings or individual exercises such as 'therapeutic writing'	Quantitative analysis; review of moderators of treatment effect sizes and outcomes for a broad span of self-help; depressive symptoms only

Review	Focus and type of problem	Method of review	Description of intervention	Main difference from current review
Khan et al. (2007)	Guided self-help for depression in primary care	Meta-synthesis	N/A - consideration of patient experience	Qualitative overview; examining patient experience of/ attitudes towards management of depression using guided self-help
Morgan et al. (2008)	Self-help interventions for depression	Systematic review	Herbal remedies and dietary supplements; caffeine; dietary methods; psychological methods; bibliotherapy; lifestyle changes; physical and sensory methods	Broad range of self-help; specific focus pure self-help; depression only
Den Boer et al. (2009)	Paraprofessional input for anxiety and depressive disorders	Systematic intervention review	Paraprofessional intervention with a range of interventions from alternative approaches	Focus on broad paraprofessional input or peer-support (e.g., paraprofessional-led befriending groups or telephone support) rather than text-based guided self-help; depression only
Cuijpers et al. (2010)	Guided self-help versus psychotherapy for depression and anxiety	Systematic review and meta-analysis	Guided self-help with written, audio or video materials	Inclusion of broader guided self-help technologies; comparison of effectiveness

However, there is limited evidence examining the reporting of attrition in outcome studies and how it relates to satisfaction with and adherence to self-help materials.

Aims of the current review

As guided self-help comes in many forms and most prior reviews have had a much broader remit (considering effectiveness, both guided and unguided self-help, a variety of formats, etc.), the focus of the current review will exclusively be on assisted bibliotherapy. The aims here are narrower: to explore the relationship between adherence, attrition and satisfaction in outcome research on assisted bibliotherapy within a primary care community setting, and to draw together potential evidence that may inform efforts to improve low-intensity services.

Method

The current review is limited to quantitative studies of assisted bibliotherapy using comparison groups or longitudinal designs that allow some degree of causal inference to be made about differences between groups or across time.

Inclusion and exclusion criteria

Characteristics of the guided self-help intervention

Studies were included if assisted bibliotherapy (i.e., not pure bibliotherapy or conventional one-hour therapy sessions with a supplementary book) was being evaluated in at least one of the groups; the purpose was to reduce clinical symptoms of anxiety and/ or depression; and the content and structure of the self-help materials and sessions were based on cognitive-behavioural techniques.

Target problems/ population

Studies were included if the guided self-help was targeted at adults with depression and/ or anxiety. This criterion was broadly interpreted to include vaguely defined problems such as “low mood”, “stress” or “worry”. Substance misuse, addictions, eating disorders and health-related problems were excluded because these are distinct specialisms each with a substantial guided self-help literature of their own. Studies of guided self-help for children, older adults and highly specific populations (e.g., war veterans) were also excluded.

Outcome Measures

Studies were included if they reported at least one validated and standardised measure of psychological functioning, satisfaction or acceptability.

Setting

Studies were included if participants were recruited from and/ or were offered the intervention within a primary care community setting. Studies within secondary care community or specialist contexts were excluded.

Research Design

Studies were included if they used a comparison group or a prospective longitudinal design comparing two or more time-points. Purely qualitative studies were excluded.

Search Strategy

Three strategies were adopted to identify all relevant studies published prior to the cut-off date of October 2010. First, the following databases were searched from 2000 to October 2010: CINAHL Plus, which focuses on nursing-orientated research; Embase and Medline, which focus on biomedicine and the life sciences; PsychInfo, which focuses on psychological research.

Relevant search terms were identified and grouped into five categories (see Table 2): intervention, paraprofessional, setting, presenting problem and attrition. Within each category, initial searches were performed on each of the individual search terms (guided self- help, self-help, self-management, etc.) and the results generated for each of the individual terms were combined using the 'OR' operator, which generated a greatly over-inclusive number of studies for each category. When these results were then combined across each category using the 'AND' operator, only three suitable studies were generated (Farrand et al., 2008; Lovell et al., 2008; Mead et al., 2005). Consequently, the search results for terms within the 'intervention', 'setting' and 'presenting problem' categories were electronically combined and studies not fulfilling the remaining criteria were excluded manually. This was done by considering the title and abstract, and then reading the full text where necessary.

References from existing reviews of the literature in this area were also examined. Finally, potential papers were identified through recommendations by colleagues in the field. Only studies focusing on adults of working age reported in English-language papers published in peer-reviewed journals were considered for the

Table 2: Initial search categories and terms for the current review

Category	Intervention	Paraprofessional	Setting	Presenting problem	Attrition
Search terms	guided self-help self-help self-instruction self-management bibliotherap* minimal intervention low-intensity intervention brief intervention minimal contact	paraprofessional* non-professional low-intensity mental health worker* graduate mental health worker* primary care mental health worker*	primary care primary health care family practice general practice	anxi* (ious/ iety) depress* (ive/ion/ed) stress* worry mood disorder* low mood affective disorder	drop out* dropout* adherence treatment compliance attrition early termination attendance

review. Judgments about eligibility were made by the author and then by her supervisor in case of doubt.

A substantial number of exclusions were based on target problem. The majority of subsequent exclusions were due to characteristics of the intervention, with further exclusions based on design. Studies that met the design criterion consistently met the criterion for outcome measures, except one study that did not feature a psychological outcome measure and was therefore excluded.

Analysis

The initial plan for analysis was to gather information on each of the factors (i.e., adherence, satisfaction, attrition and outcome), separate them into low, medium and high categories, and then compare ratings both within and across trials with the other factors (i.e. were reports of good adherence correlated with good outcomes) to assess whether any relationship could be found. As will be discussed later, inconsistent measurement and reporting precluded a systematic meta-analytic approach or even a less formal box score tally. Consequently, the reviewing procedure used a narrative review method.

Results

Fifteen studies met the inclusion criteria: seven used randomised controlled trial designs (RCTs) to evaluate the intervention, two used non-randomised designs and six used uncontrolled designs (see Table 3). All studies used at least one standardized outcome measure of psychological functioning, most commonly the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM; Evans et al. 2000), Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) or Beck Depression Inventory-II (BDI-II; Beck, Steer & Brown, 1996). All studies used self-report outcome measures, but use of therapist or independent assessor' ratings was rare.

Sample sizes ranged from five to over 650, but the majority featured between 50 and 150 participants. Women consistently outnumbered men, usually by 2:1. Age was inconsistently reported, but for those studies that did report it, participants were usually in their thirties or forties. Severity of target problem was not uniformly reported; where it was, the range was broad incorporating mild to severe. Those deemed to be acutely at risk or experiencing psychosis were excluded and participants taking medication were accepted if the dose was stable. The studies were from the UK, bar one each from Australia, Taiwan and The Netherlands. Methodological details of the individual studies are outlined in Table 4, and summaries of the interventions and outcomes are described in Table 5.

The standard of reporting of procedures and findings was mixed. Some studies gave detailed information on attrition, but overall the number of eligible participants at each stage (i.e., those consented, randomised, attended, withdrew, did not return questionnaires, featured in the reported analyses) was not always transparent. A brief summary of the main findings of each study according to design now follows, with a consideration of attrition, adherence and satisfaction (see Table 6). The definitions of

Table 3: Summary of clinical and methodological characteristics

Characteristics	Number of studies
<i>Target problem</i>	
Anxiety and/ or depression	8
Anxiety only	4
Depression only	3
<i>Para/professional</i>	
Mental health professional	7
Non-mental health professional	3
Graduate/ Primary Care Mental Health Worker	2
Assistant Psychologist	2
Research staff	1
<i>Nature of Intervention</i>	
Bibliotherapy with predominantly face-to-face contact	12
Bibliotherapy with predominantly telephone contact	1
Bibliotherapy with predominantly email contact	1
Bibliotherapy, internet site or computer programme with face-to-face contact	1
<i>Design</i>	
Randomised controlled trial	7
Non-randomised controlled trial	2
Uncontrolled design	6
<i>Comparison group*</i>	
No comparison group	6
Delayed-intervention intervention control	4
Increasing levels of contact	2
Treatment as usual	2
No treatment waitlist-control	1
Other form of guided self-help	1
<i>Number of measurement points</i>	
Two	5
Three	7
Four or more	3

*Total of 16 because one study (Bilich et al., 2008) compared increasing levels of contact *and* had a delayed-intervention control group

Table 4: *Description of design features*

Author date	Target problem	Control / comparison group	Assessment points	Outcome measures
Power et al. (2000)	Panic and agoraphobia	Standard, minimal, pure	Baseline, 6 weeks, 12 weeks, 6 months	Assessor-rated Hamilton Anxiety Scale; patient-rated Symptom Rating Test; Montgomery Asberg Depression Rating Scale; Fear Questionnaire (Agoraphobia subscale); panic diary
Ekers et al. (2003)	Anxiety and/ or depression	None	Baseline, final session (variable), 3 months	34-item CORE-OM; Work and Social Adjustment Scale
Lovell et al. (2003)	Anxiety and/ or depression	None	Baseline, 3 months, 6 months	18-item CORE
Richards et al. (2003)	Anxiety and/ or depression	Treatment as usual	Baseline, 1 month, 3 months	34-item CORE-OM; EuroQol-5D; Poulton Consultation Satisfaction Questionnaire; 12- item GHQ
Mead et al. (2005)	Anxiety and depression	Waitlist-control	Baseline, 3 months	14-item HADS; 21-item BDI; 34-item CORE- OM; 45-item Social Adjustment Scale; self- report 8-item questionnaire on therapeutic alliance and satisfaction; 10-point patient preference scale

Author date	Target problem	Control / comparison group	Assessment points	Outcome measures
Reeves et al. (2005)	Stress and anxiety	None	Baseline, post-treatment, 3 months	34-item CORE-OM; Zung anxiety inventory
Lovell et al. (2006)	Common mental health problems	None	Baseline, 3 months	34-item CORE-OM; service utilisation and efficiency (assessed through audit); semi-structured interviews assessing user satisfaction and referrer/ self-help clinic worker acceptability
Van Boeijen et al. (2007)	Panic Disorder and GAD	None	Baseline, 12 weeks	12-item GHQ; Spielberger State-Trait Anxiety Inventory; Lehrer-Woolfolk Anxiety Symptom Questionnaire
Bilich et al. (2008)	Depression	Enhanced contact, Minimal contact, Delayed-intervention control	Baseline, 8 weeks, 12 weeks; Control group: as above plus 8 weeks post-baseline	BDI-II (screening measure); 7-item subscale of DASS-21; Kessler Psychological Distress scale
Farrand et al. (2008)	Anxiety and depression	None	Baseline, final regular session (variable), 3 months	14-item HADS
Lovell et al. (2008)	Depression	Treatment as usual	Baseline, 3 months	BDI-II, 34-item CORE-OM; 9-item PHQ; Social Adjustment Scale-SR;
Liu et al. (2009)	Depressive symptoms	Delayed-intervention control	Baseline, 1 month, 3 months; Control group: as above plus 4 weeks post-baseline	BDI-II, Self-control Schedule; bespoke treatment compliance and comprehension questionnaire

Author date	Target problem	Control / comparison group	Assessment points	Outcome measures
Pittaway et al. (2009)	Mild to moderate depression and / or anxiety	Three guided self-help comparison groups	Baseline, 8 weeks	34-item CORE-OM; bespoke satisfaction questionnaire
Lucock et al. (2010)	Mild to moderate depression and / or anxiety	Delayed-intervention control	Baseline, Sessions 1 and 2, review session (variable), 3 months; Control group: as above plus 8 weeks post-baseline	34-item CORE-OM
Reeves (2010)	Mild to moderate stress and anxiety	Delayed-intervention control	Baseline, 8 weeks, 3 month follow-up; Control group: as above plus 8 weeks post-baseline	34-item CORE-OM; 14-item HADS; bespoke satisfaction questionnaire; bespoke compliance questionnaire

Note: BDI, Beck Depression Inventory; CORE-OM, Clinical Outcomes in Routine Evaluation Outcome Measure; DASS, Depression Anxiety Stress Scale; GHQ, General Health Questionnaire; HADS, Hospital Anxiety and Depression Scale; PHQ, Patient Health Questionnaire

Table 5: Summary of intervention and outcome

Author date	Description of intervention	Duration of intervention¹	Outcome
Power et al. (2000)	CBT self-help text, sessions with a clinical psychologist in GP surgery (psychoeducation, exposure exercises), three levels of contact - Standard: assessment and eight 45-minutes sessions plus; Minimum: assessment and three 10-minute sessions; No contact: manual only	12 weeks	Standard and minimum contact showed equivalent significant improvement on all measures
Ekers et al. (2003)	CBT self-help text, up to ten 15-minute sessions on self-management and problem-solving with a pilot self-help clinic (worker's profession not stated)	Variable - up to 12 weeks	Statistically and clinically significant improvement
Lovell et al. (2003)	CBT self-help text, 15-minute sessions (usually fortnightly) with a nurse therapist (mean = 3.4), behavioural, cognitive and lifestyle advice	Variable – estimated mean seven weeks	Clinically significant and reliable change for 48% of participants after three months
Richards et al. (2003)	CBT self-help text, three sessions facilitated by a practice nurse: first two appointments, offered 1 week apart; one follow-up appointment; or treatment as usual	12 weeks	Clinically significant change for 29% for guided self-help and treatment as usual at three months
Mead et al. (2005)	CBT self-help text, up to four 15-30-minute sessions with an assistant psychologist (psychoeducation, description of others' experience, description of CBT principles, CBT exercises, e.g., cognitive restructuring); or waitlist-control	Variable – up to 12 weeks	Modest benefits resulting from the intervention but no discernable difference from the waitlist-control group

¹ Estimated if exact details were not given

Author date	Description of intervention	Duration of intervention¹	Outcome
Reeves et al. (2005)	CBT self-help text, seven weekly 20-minute sessions (psychoeducation, description of CBT principles, CBT exercises, e.g., cognitive restructuring) with a CBT nurse therapist	7 weeks	Significant improvement post-treatment, maintained at follow-up
Lovell et al. (2006)	CBT self-help text, initial 45-minute assessment and up to ten 15-minute follow-up sessions with a trained therapist (nurse/ counsellor/ social worker), (problem solving and monitoring of progress)	Variable – up to 12 weeks	Clinically significant improvement at three months for 39%
Bilich et al. (2008)	CBT self-help text, telephone sessions with a free-phone mental health service volunteer; Enhanced: weekly phone contacts up to 30 minutes (discussed problem-solving and goal-setting); Minimal contact: weekly phone contacts up to 5mins; control waitlist group: no assistance)	8 weeks	Both enhanced and minimal contact groups had equivalent significant improvements post-treatment; enhanced group only demonstrated further improvement at follow-up
Farrand et al. (2008)	CBT self-help text (34 different self-help texts available), initial assessment followed by a two-plus-one model (in practice, it was more often a three-plus-one model), two weekly or fortnightly 20-minute support sessions plus one follow-up session at 3 months with a PCMHW	12 weeks	Clinically significant and reliable change for 63% at three months follow-up

Author date	Description of intervention	Duration of intervention¹	Outcome
Lovell et al. (2008)	CBT self-help text, CD and diaries with up to ten 15- to 30-minute sessions from a health-care professional (social worker, occupational therapist, nurse, PCMHW), (psychoeducation, formulation, progress review), sessions were occasionally delivered by phone or email	12 weeks	Improvement for both groups, but no significant difference between the groups
Liu et al. (2009)	CBT self-help text, weekly emails from research staff and phone contact at any time; or delayed intervention control group	4 weeks	Significant improvement post-treatment for intervention group
Pittaway et al. (2009)	Three guided self-help interventions: CBT self-help text, computer programme or website assisted by an assistant psychologist; all received an introduction to the materials a final assessment of progress but had differing amounts of support allocated to each	8 weeks	Equivalent significant improvement post-treatment for all groups
Van Boeijen et al. (2007)	CBT self-help text, exercise book, relaxation tape, leaflet for a helper, five 20-minute sessions with a trained CBT therapist (psychoeducation, motivation, problem-solving, homework)	12 weeks	Significant improvements on outcome measures; 2 of 5 demonstrated clinically significant and reliable change

Author date	Description of intervention	Duration of intervention¹	Outcome
Lucock et al. (2010)	CBT self-help text, screening assessment, two 60-minute sessions and one 30-minute review session with a PCMHW (psychoeducation, goal setting, CBT strategies); or delayed-intervention control group	8 weeks	Clinically significant and reliable change for 47% post-treatment
Reeves (2010)	CBT self-help text, seven weekly 30-minute sessions (psychoeducation, description of CBT principles, CBT exercises, e.g., cognitive restructuring) with a CBT nurse therapist	7 weeks	Significant improvements post-treatment

Table 6: Summary of attrition, satisfaction and adherence*

Author and date	Group	Baseline group <i>n</i> (overall <i>n</i>) ¹	Time-point 1 ² (% of baseline <i>n</i>)	Time-point 2 (% of baseline <i>n</i>)	Time-point 3 (% of baseline <i>n</i>)	Time-point 4 (% of baseline <i>n</i>)	Time-point 5 (% of baseline <i>n</i>)	Details given on satisfaction	Details given on adherence
<i>RCT</i>									
Power et al. (2000)	1. Standard SH	37 (104)	0 (0)	6 (16)	7 (19)	14 (38)	N/a	No	No
	2. Minimal SH	32 (104)	0 (0)	1 (3)	2 (6)	9 (28)	N/a	No	No
	3. Pure SH	35 (104)	0 (0)	6 (17)	16 (46)	18 (51)	N/a	No	No
Richards et al. (2003)	1.AB	75 (139)	16 (21)	41 (55)	55 (73)	N/a	N/a	Yes	No
	2. TAU	64 (139)	17 (27)	31 (48)	43 (67)	N/a	N/a	Yes	No
Mead et al. (2005)	1. AB	57 (114)	7 (12)	7 (12)	N/a	N/a	N/a	Yes	Yes
	2. Waitlist-control	57 (114)	0 (0)	4 (7)	N/a	N/a	N/a	N/a	N/a
Bilich et al. (2008)	1. Enhanced AB	21 (84)	0 (0)	4 (19)	5 (24)	N/a	N/a	No	Yes

* Some figures displayed are estimated as some losses were not adequately quantified within the text; percentages are rounded to the nearest whole number

¹ Referred, considered eligible after initial screening/ assessment, consent obtained and randomized where appropriate

² Data not available at time-point 1 (baseline/ initial assessment) for those who had initially consented to participate; this also applies to all other time-points

Author and date	Group	Baseline group <i>n</i> (overall <i>n</i>) ¹	Time-point 1 ² (% of baseline <i>n</i>)	Time-point 2 (% of baseline <i>n</i>)	Time-point 3 (% of baseline <i>n</i>)	Time-point 4 (% of baseline <i>n</i>)	Time-point 5 (% of baseline <i>n</i>)	Details given on satisfaction	Details given on adherence
	2. Minimal AB	23 (84)	0 (0)	6 (26)	7 (30)	N/a	N/a	No	Yes
	3. No contact (delayed)	40 (84)	0 (0)	6 (15)	15 (38)	20 (50)	N/a	No	No
Lovell et al. (2008)	1. AB	29 (59)	7 (24)	10 (34)	N/a	N/a	N/a	Yes	No
	2. TAU	31 (59)	1 (3)	8 (26)	N/a	N/a	N/a	No	N/a
Liu et al. (2009)	1. AB	27 (53)	0 (0)	6 (22)	Not reported	N/a	N/a	Yes	Yes
	2. Delayed treatment control	26 (53)	1 (4)	7 (27)	Not reported	Not reported	N/a	Not Clear	Not Clear
Lucock et al. (2010)	1. Immediate-treatment	63 (122)	10 (16)	7 (11) ³	19 (30)	29 (46)	Not reported	No	No
	2. Delayed-treatment control	59 (122)	10 (17)	10 (17)	10 (17)	19 (32)	25 (42) ⁴	No	No
<i>Non-randomised</i>									
Pittaway et al. (2009)	1. PC program	28 (88)	0 (0)	12 (43)	N/a	N/a	N/a	Yes	No

³ Participants for whom data were unavailable at the previous time-point were available at this time point

⁴ As with the immediate-treatment group, details of the follow-up session for the delayed-treatment group were not reported

Author and date	Group	Baseline group <i>n</i> (overall <i>n</i>) ¹	Time-point 1 ² (% of baseline <i>n</i>)	Time-point 2 (% of baseline <i>n</i>)	Time-point 3 (% of baseline <i>n</i>)	Time-point 4 (% of baseline <i>n</i>)	Time-point 5 (% of baseline <i>n</i>)	Details given on satisfaction	Details given on adherence
	2. Book	26 (88)	0 (0)	11 (42)	N/a	N/a	N/a	Yes	No
	3. Website	34 (88)	0 (0)	15 (44)	N/a	N/a	N/a	Yes	No
Reeves (2010)	1. AB	Not clear (52)	0 (0)	Not possible to calculate	Not possible to calculate	N/a	N/a	Yes	Yes
	2. Delayed-treatment control	Not clear (52)	0 (0)	Not possible to calculate	Not possible to calculate	N/a	N/a	No	No
<i>Uncontrolled design</i>									
Ekers et al. (2003)	1. AB	26	9 (35)	15 (58)	17 (65)	N/a	N/a	Yes	No
Lovell et al. (2003)	1. AB	137	33 (24)	53 (39)	77 (56)	N/a	N/a	Yes	No
Reeves et al. (2005)	1. AB	11	0 (0)	2 (18)	3 (27)	N/a	N/a	Yes	Yes
Lovell et al. (2006)	1. AB	376	84 (22)	274 (73)	N/a	N/a	N/a	Yes	No
Van Boeijen et al. (2007)	1. AB	5	0 (0)	0 (0)	N/a	N/a	N/a	No	Yes
Farrand et al. (2008)	1. AB	658	79 (12)	200 (30)	425 (65)	N/a	N/a	No	No

Note: AB, Assisted bibliotherapy; SH, self-help

these factors are deliberately broad for the purposes of this review due to dissimilar levels of detail and clarity in reporting.

Attrition incorporates i) disengagement from the intervention/ study, ii) withdrawal of consent to use data, and iii) insufficient or missing data for psychological outcome measures (if there were multiple outcome measures, data was not counted as unavailable if there was usable data for at least one of the measures). Cumulative percentage rates of attrition (drop out or unavailable data) over time are presented to facilitate comparisons across studies, and represent the unavailable data within the listed condition out of the total number of people who were deemed eligible and consented to participate at the beginning of the study. Adherence refers to participants' use of the materials (e.g., number of chapters read; homework tasks attempted). It does not refer to the para/professionals' adherence to a treatment protocol, but this will be discussed where relevant. Finally, satisfaction relates to reports of the extent to which participants found the intervention relevant, appropriate and useful.

Randomised controlled trials

Seven studies used randomised controlled designs. Two compared assisted bibliotherapy with treatment as usual (TAU), two compared differing levels of assistance (one of these also featured a delayed-treatment control group), two compared immediate intervention with a delayed-treatment control, and the remaining study compared an intervention group with a control group where both were waiting for traditional psychological therapy. All studies discussed attrition, with varying degrees of detail. Three studies discussed satisfaction and adherence, although again, detail is variable, and two studies did not address these factors at all.

Power, Sharp, Swanson and Simpson (2000) examined the comparative efficacy of sessions with a clinical psychologist plus a self-help manual with three levels of contact (standard, minimal and no contact). Symptomatology reduced for

all groups over time, with more significant gains as contact increased. On several measures, minimal contact was not statistically different from standard, but increased contact resulted in higher rates of clinical change and increasing numbers reporting 'panic-free' status at the 12-week end-point.

Overall, the study was of a good standard and clear attempts were made to control for bias (e.g., using an independent assessor rather than relying solely on self-report). It also considered issues such as clinically significant change and use of other interventions at follow-up. Attrition was reported but links with satisfaction and adherence cannot be made as these factors were overlooked. The minimal contact group had the lowest dropout rates, followed by the standard then no-contact groups, in this case, suggesting that increased contact did not equate to reduced attrition. Those who discontinued (due to effectiveness or ineffectiveness) before the end-point but after the halfway stage of six weeks were included in the final analysis, as they were deemed 'completers'. All groups experienced most loss at the end-point after three months with data unavailable for between 28% and 51%, and the no-contact group having consistently high losses at each time-point.

Richards, Barkham, Cahill, Richards, Williams and Heywood (2003) compared TAU with bibliotherapy assisted by a practice nurse and reported reduced distress over time for both groups. The reduction in the assisted group was initially greater, with scores for 47% of the guided self-help group (and 18% of the TAU group) falling below clinical cut-off on the CORE-OM after one month, but after three months the difference no longer remained. At one-month follow-up, satisfaction ratings were higher for the guided self-help group. However, it is debatable whether the 0.53 difference in satisfaction on a five-point scale is clinically relevant, and satisfaction was equivalent for both groups at 3-month follow-up. The authors also consider the possibility that the increased satisfaction ratings in the assisted group may be due to non-specific effects (e.g., contact with an attentive listener), rather than the intervention itself.

Strengths of this study included clear description of design, procedure and results; the monitoring of health-care service usage and quality of life in addition to standard measures of psychological functioning; the use of a booklet that had featured in a prior successful primary care trial; and intervention cost being no more than ordinary care. However, there were several weaknesses, including a lower than expected recruitment rate, no consideration of adherence, mistakes with blind allocation and significant attrition. At baseline, 21% of the 75 eligible participants withdrew or did not complete outcome measures, compared to 27% for the TAU group. These significant losses were mirrored at the end of the intervention and at 3-month follow-up for each group. Overall, data for 73% of the intervention group and 67% of the control group were unavailable at the final follow-up point, and such heavy losses limit the generalisability of these results and conclusions.

Mead et al. (2005) presented a clearly reported pragmatic trial of assisted bibliotherapy from an assistant psychologist, in which people waiting for conventional psychological therapy were randomly assigned to guided self-help or a waitlist-control group. Patients were followed up three months later prior to starting therapy. Despite modest benefits resulting from the intervention and no discernable difference from the waitlist-control group, the rate of attrition was low compared to other studies. At 3-month follow-up, data was unavailable for only 12% of the 57 participants in the assisted group, and 7% of the 57 control participants.

It is possible that the design may account for the low attrition (i.e., potential concern that dropping out would somehow negatively affect the chances of receiving therapy). However, those who completed satisfaction measures reported a high degree of satisfaction with the materials (over 90% indicating they would continue to use them), which could also account for the low attrition. High levels of satisfaction with the assistant psychologist who offered the support were also reported. However, while the mean score for the satisfaction scale is given, the points range is not, so degree of satisfaction is difficult to reliably gauge. The views of a selection of

participants are presented in a separate qualitative study (Macdonald, Mead, Bower, Richards & Lovell, 2007).

Seventy-five per cent of participants provided adherence data. Reported adherence to recommended strategies was variable; 45% kept an activity diary, 52% reported doing the exercises at least weekly, 88% reported reading at least half of the manual and 100% tried to look at thoughts in a different way. The study has reasonable internal validity, as it benefits from observance of CONSORT (Consolidated Standards of Reporting Trials) guidelines (Moher, Schulz & Altman, 2001), concealed allocation and sufficient power to detect a medium effect. However, external validity is limited given that 80% of potential patients on the waiting list declined the offer of assisted bibliotherapy.

In an interesting Australian study by Bilich, Deane, Phipps, Barisic and Gould (2008) on a community-based dissemination strategy for rural areas, participants received a self-help book and different levels of telephone support (enhanced, minimal and no contact) from free-phone mental health service volunteers (similar to The Samaritans in the UK). The group who received no contact also acted as waitlist controls, as they had to wait eight weeks prior to receiving the self-help book. The greatest symptom reduction was observed in the group with most contact and treatment gains were maintained at follow-up. Clinically significant change occurred for many in the contact groups, but symptoms decreased only marginally for the book-only group.

The authors did not discuss satisfaction, but gave information on adherence. Current page number, number of activities completed and self-reported adherence ratings were recorded weekly. However, details were brief and not listed by group: 85% of participants in contact groups reported completing the book and, on average, two exercises were completed by each participant per week. Adherence for the book-only group was not presented. Attrition was between 19% and 38% across the groups at the end of the intervention, with the lowest loss from the

enhanced contact group. Unlike other studies, losses at follow-up for contact groups were minimal. The no-contact group had the highest rate of attrition throughout.

The intervention and procedure were clearly described. While aspects of the recruitment strategy potentially limit the generalisability to clinical populations in NHS settings (e.g., recruitment through radio and newspaper advertisements), there are interesting links to be made with primary care community outreach services in rural areas of the UK, and their relevance will be explored within the discussion.

Lovell et al. (2008) presented an exploratory trial of assisted bibliotherapy with 'self-help coaches' (PCMHWs, nurses and social workers), but despite being developed from an in-depth modelling phase, no significant benefit over TAU was found. Take-up and attrition were also problematic; half of the anticipated numbers of participants were recruited and, at baseline, 3% of the TAU group and a quarter of the assisted group dropped out. By the end-point, around a third of the intervention group had dropped out compared to around a quarter of the TAU group.

While participant adherence was not discussed, details of training, supervision and therapists' fidelity to protocol were provided. A weakness noted by the authors was that therapist adherence to the manual reduced as sessions progressed, and they argued that the small sample size and 'incorrect dosage' might have masked an effect (despite having a recommended range of three to ten sessions, 41% participants received fewer than three).

Satisfaction was explored using semi-structured interviews and, overall, the materials and assistance were positively appraised, with stories of recovery within the booklets being particularly well received. Participants considered the guidance and advice to be practical, empowering and important in maintaining motivation. They described themselves as feeling much better following the intervention, and suggested that they would continue to use the techniques. However, this may be an inflated account of satisfaction, as only nine of the 22 participants who attended

sessions agreed to be interviewed, and there were limited differences in outcome between groups.

In another international study, Liu et al., (2009) examined the use of a translated American self-help text for the Chinese community in Taiwan. Immediate- and delayed-treatment groups received weekly email or telephone assistance from research staff, and symptoms of depression were reduced post-treatment, with further reported reductions at follow-up. However, figures on follow-up data and the delayed-treatment group were omitted. At their respective end-points, around 22% of participants from the immediate group and 27% from the delayed group had dropped out.

Participant adherence and satisfaction were reported, although it was not made explicit whether reports were from the immediate-intervention group or both groups combined. Adherence, examined through self-reported number of chapters read and number of thought records completed, was discussed briefly: authors stated that it was not related to outcome. Satisfaction was assessed using an open-ended feedback questionnaire. Strengths listed included “convenience, no need to talk to others, enjoyment in reading, provision of well-organised and theory-driven information, being able to understand and challenge negative thoughts using multiple methods, and prevention of a depressive episode”. Weaknesses listed included “not being able to concentrate on reading when feeling low, lack of personal supervision, not being able to complete the exercise by oneself and the sense that a book could never compare to support from loved ones”. The book was considered easy to read, and although participants indicated that thought records required time and patience, they were judged to be worthwhile. However, participants did not understand some of the “jargon”, characters and situations were not deemed culturally relevant, and worksheets were considered to be difficult to complete without direct help from a therapist.

While recruitment was within a community primary care setting (GP surgeries and university faculties), as with Bilich et al. (2008) it was not within a state-funded UK-style service and participants received payment for participation, thus limiting external validity. Nevertheless, there are potential parallels between the participants in this study and migrant communities in the UK, which will be discussed below.

In the final RCT, conducted by Lucock, Kirby and Wainwright (2010), participants were provided with self-help materials by an independent assessor at an initial screening session then were randomly allocated to an immediate- or delayed-intervention group receiving assistance from a PCMHW. Between the initial screening session and the eight-week review session, 47% showed a reliable and clinically significant improvement (although it is not clear whether this refers to the immediate-treatment group or both groups). However, there was also a sizable improvement between the screening and first session (within approximately two weeks), despite participants reporting not having read the materials, indicating a degree of spontaneous remission and/ or the positive impact of expectation. No change was observed between the review session and follow-up.

With regard to attrition, the study suffered heavy losses by the end of the intervention with data unavailable for 46% of the immediate-treatment group and 42% of the delayed group. The reporting on attrition was commendable, as important information such as the numbers who attended *and* completed the outcome measures were given separately. A limitation of this otherwise comprehensively described study was that satisfaction and adherence were not considered or discussed.

In summary, no group-related pattern of attrition was found for the RCTs outlined here, and the exactness of reporting was variable. The overall rate of loss was substantial for several studies, with four reporting losses of 40% or more for a particular group over the course of the study, the highest being 73%. Adherence

was considered in three studies and, while reported briefly, could be described as sufficient to good. Participants gave broadly positive ratings of satisfaction, but it was not clear whether ratings were based solely on the materials or whether they also related to the worker and the format, or indeed, the delivery and timing of the intervention. An additional weakness was that satisfaction for the non-intervention groups was not routinely measured or presented. Unfortunately, it was not possible to perform a more systematic analysis of associations between satisfaction, adherence, attrition and outcome due to inconsistent selection of measures across studies and variability in detail of reported results.

Non-randomised controlled trials

Pittaway et al. (2009) compared the use of three well-established self-help tools facilitated by a psychology graduate from the mental health charity MIND. Following a referral by their GP, participants were consecutively allocated to the use of a computer programme, a book or a website. Each group demonstrated a significant reduction in symptomatology after eight weeks with no significant differences across groups. Post-treatment, each group was characterised by high attrition (around 40%).

Twenty-eight of the 50 participants that completed the intervention returned the satisfaction questionnaire that was inexplicably given after a delay of six months rather than at the end of the intervention, an interval likely to reduce the reliability of reporting. Overall reporting of satisfaction was presented briefly and somewhat ambiguously. It was not clear if the patient satisfaction, patient evaluation and service evaluation questionnaires that are mentioned are distinct entities. It is reported that no significant differences were found between groups at six months on the 'patient satisfaction' questionnaire, but the questionnaire items and the degree of satisfaction are not mentioned. Responses to questions on the 'service evaluation' questionnaire about accessibility and clarity of information about the service were 'strongly positive' (86% and 84% respectively). Seventy-three per cent reported that

they would recommend the intervention to others and over 40% said that they would consider it a useful alternative form of treatment to counselling and medication; however, differences in satisfaction across groups were not made clear.

The study had limited rigour due to the design (i.e., lack of control group and differing level of support across groups), thus diminishing the reliability of conclusions about the relative influence of the alternative interventions. Nonetheless, the authors defended their design, as they stated that their aim was to assess feasibility, not effectiveness. Adherence was not discussed, and a further weakness was the missed opportunity to repeat outcome measures when participants were contacted about satisfaction at the six-month time-point.

Using a non-randomised delayed-treatment control design, Reeves (2010) found clinically significant improvements for both the immediate- and delayed-intervention group at their respective end-points, which were maintained after three months. However, several flaws reduced the quality of this study and, therefore, the conclusions about effectiveness and utility may be somewhat exaggerated. First, the standard of analysis and reporting was disappointing. The study was underpowered with a small sample, and 15% of the total initial sample of 52 were excluded from analysis (eight dropped out and one failed to return questionnaires), but it was not clear from which group/s they originated. Furthermore, information presented in tables was ambiguous or did not match that presented in the text (it is reported that 16 people from the treatment group completed follow-up measures, but data for only twelve are presented within figures).

Reporting on satisfaction was clearer, but brief: all participants in the immediate-treatment group (satisfaction for the delayed-treatment group was not assessed) who completed the intervention completed the satisfaction questionnaire and rated the intervention as 'quite helpful' or 'very helpful'. Adherence was assessed using a brief questionnaire. Clients reported using all aspects of the assisted bibliotherapy, although some infrequently. Fifty-three per cent of

respondents 'often' used the techniques in difficult situations, and 14% used them 'very often'. All respondents reported using the techniques at least 'sometimes', and 53% suggested they were 'becoming a part of their daily lives'. However, it was not stated whether this was based on reports from the immediate intervention group or both combined.

Uncontrolled designs

Six studies examined the impact of assisted bibliotherapy without the use of a control or comparison group. Two studies discussed adherence, and four discussed satisfaction.

Ekers and Lovell (2003) conducted an audit of a three-month pilot self-help clinic for anxiety and depression. Participants were assisted by a trained CBT therapist and given materials, written by one of the research team, which had been efficacious in a previous study. Statistically and clinically significant gains were found post-intervention. However, the study was weakened by the small sample and subsequent use of non-parametric tests, and by high attrition: nine of 26 people who attended an assessment took the manual, but did not return; three only attended one session; a further three dropped out earlier than planned and did not return their evaluation forms; and two more were unavailable at follow-up.

Adherence was not discussed, but satisfaction was considered. Clinic users were asked about satisfaction, whether they would return to the clinic if necessary and whether they would recommend it to others. The service was well evaluated on all counts (means between 4.36 and 4.72 on a 5-point scale) by all eleven users who completed the intervention, but the authors rightly mention that the ratings may not be representative of those who did not return their questionnaires. GPs and clinic staff also indicated high satisfaction.

Similarly, Lovell et al. (2003) reported an evaluation of a pilot guided self-help clinic led by an experienced CBT therapist, and succinctly outlined the acceptability, efficiency and effectiveness of the intervention. Of those for whom

data was available, clinically significant and reliable change occurred for 48% and 61% of the initial sample at the three- and six-month follow-up respectively. However, there was significant attrition, with 18% attending one appointment only and data unavailable for 39% and 56% of the initial sample at three- and six-month follow up.

Adherence to the materials was not discussed, but participant and referrer satisfaction were considered. It is reported that the high rate of referral indicated that the clinic was 'acceptable' to the referrer, although other factors, such as pressure to try something new, could also explain this. Participant satisfaction was high, as 90% of the 60% who responded suggested that they were 'satisfied' or 'very satisfied', would 'definitely' or 'probably' use the clinic again and would 'definitely' or 'probably' recommend the clinic to others. This is expanded upon in a supporting qualitative study (Rogers, Oliver, Bower, Lovell & Richards, 2004). The report is brief but has a number of interesting features, such as monitoring of health service use and referral elsewhere. However, as the authors admit, design limitations reduced the possibility of drawing solid conclusions.

In an earlier study to that previously reported here by the same first author, Reeves and Stace (2005) examined the use of CBT therapist-assisted bibliotherapy and found a significant improvement post-treatment, which was maintained at follow-up. However, again the quality of the study and its conclusions are open to question. First, the inferior sample size required non-parametric analyses. Second, the nine 'completers' were compared with ten 'non-completers', but two of the non-completers declined the invitation to attend the first assessment and five more did not attend. They perhaps would be more accurately defined as 'non-starters' rather than 'non-completers', and while there may be an argument for making such comparisons within the discussion, it could be argued that incorporating such data in the results and analyses may be unnecessary and misleading. Furthermore, while it is reported that two of the eleven participants dropped out after session one and the

remainder completed as planned, other details on attrition were not reported; follow-up attrition was not discussed within the body of the report, but graphs indicate missing data.

Satisfaction and adherence were measured post-intervention and at follow-up, but the presentation of satisfaction was brief (75% of patients found the intervention 'very helpful') and did not consider differences across time-points. It was not clear whether adherence to materials was examined *during* the intervention, but the authors stated that post-intervention, all patients reported that they were using the self-help strategies at least 'often'. Furthermore, more than 80% indicated that the strategies were becoming part of their daily routine and that they would refer back to materials in the future if necessary. By follow-up, 80% were still using the strategies at least 'often', and the same number indicated that the strategies were 'part of life now'. Use of the materials had dropped sharply (40% suggested that they referred back 'often'), and the authors suggest that this may be because participants no longer needed to refer back to them on a regular basis. The low sample size and limitations in analysis and reporting make the evidence from this study among the weakest in the review.

Lovell, Bee, Richards and Kendal (2006) reported the results of a three-month evaluation of 34 guided self-help clinics offering appointments with experienced mental health practitioners, which also examined levels of utilization, effectiveness and stakeholder acceptability. Psychological functioning improved significantly between baseline and three-month follow-up with 69% demonstrating reliable change, 39% of which was clinically significant improvement. This study benefitted from a large initial sample, with 376 eligible participants attending at least one session; however, one third of the 662 people referred did not attend, and one third of those who did only attended one appointment. Unavailability of data was a drawback, as data were unavailable for 22% of participants at baseline and for 73%

at follow-up, which was the highest rate of loss of all of the reviewed studies. Adherence to materials was not discussed.

The study displayed several strengths including an engaging deliberation of the implications of the research in the context of existing literature, as well as a relatively detailed explored of satisfaction and the relevance to service provision. An independent researcher interviewed GPs, self-help clinicians and participants. Of the eight participants who were interviewed, six believed that the self-help clinics were appropriate for their needs, and the same number reported that attendance at the clinics had significantly improved their psychological wellbeing or daily functioning. Participants are reported to have emphasised the importance of someone to talk to and that therapeutic alliances were regarded as an important part of recovery. The authors concluded that gains were due, in part, to the development of a 'one-to-one' relationship with the self-help clinician. All regarded the materials positively and believed they had also, in part, contributed to their recovery. It is unclear how many people were invited and declined to take part, but it is stated that the response was 'relatively low'. It is also unclear how many sessions the interviewees attended, which would have given a valuable context to the accounts. It is possible that those who dropped out or those who completed treatment but declined to be interviewed may have held less positive views.

All of the ten interviewed GPs said that they would recommend the clinics as a means of treating patients with common mental health problems, with most believing that they were appropriate for all but a minority of individuals. However, several did not think that they had a clear understanding of the service aims. Most confusion centred upon the crossover between primary and secondary services. In particular, it was felt that a better definition of the self-help service and its criteria for referral was needed.

Van Boeijen et al. (2007) presented a case series of five participants who all completed an assisted bibliotherapy intervention with an experienced CBT therapist

in the Netherlands. All participants appeared to improve on all outcome measures, and two met criteria for recovery (Jacobson & Truax, 1991). However, two participants (including one of those whose scores indicated recovery) sought further psychotherapy following the intervention limiting the validity of conclusions about effectiveness and potency.

Adherence was reported in a non-standardised and idiosyncratic manner, with varying degrees of descriptive detail (e.g., “it appeared that she had spent a great deal of time on her homework”). During sessions, participants were asked if they had questions about the chapter of the manual that they had worked on and if they had carried out their homework as instructed. This was briefly remarked upon, with all but one patient reported to have spent the advised time on homework, and the mean weekly amount being around three hours.

While this study offers an interesting qualitative snapshot of the intervention and outcome, it has several omissions and biases. There was no follow-up and satisfaction was not discussed. Furthermore, besides being a member of the study team, Van Boeijen was the trial therapist and the author of the featured materials. The authors acknowledge the potential bias from her ‘competence and enthusiasm’, and rightly suggested that further testing with impartial clinicians who might use the manual would be required before more definitive conclusions about effectiveness could be drawn.

The final and largest study to be included in this review is that of Farrand et al. (2008), which offered Graduate Mental Health Worker-assisted bibliotherapy to an initial sample of over 650 people. Depression and anxiety scores dropped from mild and moderate respectively, to being marginally above non-clinical levels. Despite previously agreeing to participate, 12% did not attend the first support session, and 30% had dropped out by the end of the intervention six weeks later. At three months, data for a further 65% of the initial sample were unavailable.

Overall, this convincing study has many indicators of merit, such as the impressive sample size (which enabled robust comparisons to be made across groups), and the consideration of therapist training and supervision, efficiency, effectiveness and contextual factors involved in non-attendance. A clear narrative style of reporting made for a pertinent and engaging discussion of the research and its implications. However, there were also some limitations; participant adherence and satisfaction were not considered and missing data was not transparently accounted for at times.

In conclusion for the uncontrolled studies, the overall rate of attrition was substantial for all but one of the studies, with four reporting losses of 56% or more over the course of the study, the highest being 73%. Satisfaction and adherence were not uniformly reported and when they were, details were often scant or from a small selection of participants. Adherence was only reported in two studies (by the same author) and was generally good. As with the studies summarised earlier, participants were reported to give broadly positive satisfaction ratings, but it was not clear whether the ratings were based solely on the materials, or whether they also related to the worker and the format, delivery and timing of the intervention. Once again, inconsistency in reporting and measurement precluded a more detailed analysis of the association between the key factors under review.

Discussion

The studies presented are grouped by design and links between outcomes, attrition, adherence and satisfaction were explored. The review was intended to summarise the relevant findings on these important topics, which rarely take high priority, rather than to duplicate previous reviews that have focused principally on efficacy or effectiveness. The studies are predominantly based within NHS primary care settings in the UK; consequently, the conclusions of this review are primarily, although not exclusively, limited to this context.

Attrition was outlined in each study, but as found in a previous review (Cuijpers et al., 2010), definition of 'drop out' and subsequent inclusion (or exclusion) in analysis was variable. There were no consistent patterns of attrition across design or group. In the six studies where assisted bibliotherapy was compared with waitlist-control or TAU, perhaps surprisingly, the rate of attrition was marginally higher for the assisted bibliotherapy group. In the two studies comparing different levels of contact, reduced contact was associated with higher attrition. In the study comparing three interventions, there was equivalent attrition in each group, and the remaining studies featured an intervention group only. Excluding Van Boeijen et al., (2007), losses at baseline across studies ranged from 3% to 35% and from 7% to 73% at the final time-point.

Participant adherence to materials was explored in only six of the fifteen studies. Various assessment methods were used, including monitoring number of pages or chapters read, number of activities completed and frequency of referral to materials. Descriptions of adherence were often no more than a few lines, leaving a potentially crucial factor involved in the success of an intervention inadequately explored. Furthermore, meaningful discussion of the clinical impact of adherence and satisfaction on attrition and outcome was lacking.

Ten studies examined satisfaction and authors reported that participants expressed broadly positive views about their experiences and the materials used despite limited benefit in some cases. However, perhaps unsurprisingly, the reports of satisfaction were typically based on the respondents who had completed the intervention, and represented a minority of the initial sample. The views of those who dropped out or did not respond to the invitation to give feedback were not represented and this bias potentially inflated the positive ratings of satisfaction reported in these studies.

As both satisfaction and adherence were generally assessed using unstandardised or unvalidated bespoke questionnaires, and detail of reporting was

hugely variable, reliable comparison across studies was not possible. Similarly, comparisons between intervention and control or comparison groups on these factors could not be made, as comparisons were often absent or insubstantial. Where such comparison was reported (Richards et al., 2003; Pittaway et al. 2009), similar outcomes and rates of satisfaction and attrition were found across groups (adherence was not discussed), but meaningful conclusions cannot be drawn from this limited number of studies.

More positively, standardised psychological outcome measures were routinely used, most commonly the CORE-OM, thus enabling valid and reliable comparisons on efficacy with other studies. Another encouraging finding of the review was that reliable and clinically significant change is an increasingly popular addition to such reports, with over half of the current studies reporting on this. Consideration of efficiency and health service utilisation was an additional valuable feature within several studies.

Methodological Issues

Despite the substantial literature and on-going research into assisted bibliotherapy, both in the UK and further afield (particularly in the US), only a handful of studies met review criteria. This may be attributable to the search strategy. For example, focusing on primary care and equivalent terms could have excluded many potentially relevant international studies due to differences in health-care provision. Likewise, potentially relevant research conducted within a university, research institute or private health care setting may have been excluded.

A variety of designs were considered suitable for inclusion. While RCTs are considered the gold standard in research design, not all practitioners and researchers have the time or funding available for such large-scale endeavours. Instead, they report on what they find in their service, which can be equally as informative and useful. A well designed and carefully conducted RCT usually offers the strongest evidence to answer clinical questions on effectiveness, but this

rationale does not necessarily apply to the present review. Some of the non-randomised and uncontrolled designs outlined above had high ecological validity and potential generalisability, as the interventions documented took place within the settings that the findings were intended to be generalised to; therefore, they offered equally valid and useful information.

Irrespective of design, most studies shared a number of weaknesses. Heavy reliance on self-report measures without supplementary independent assessments and limited follow-up periods (the longest being six months) were common drawbacks among both high and low quality studies. However, this criticism should be tempered by the acknowledgement that it inevitably becomes more difficult to reliably link intervention effects with current functioning as time passes.

It was not possible to use a meta-analytic procedure or even a less rigorous analysis, such as a box score tally, to identify factors that could explain variability in reported outcomes, attrition, adherence and satisfaction (and their inter-relatedness) for several reasons. These included the small number of studies in the review and their heterogeneous nature, as well as the inconsistent selection of measures and variable detail in reporting. The definition of guided self-help was wide-ranging across the studies within the review, and this is a reflection of clinical practice and research generally. The target problems, level of symptomatology, content of materials, duration and degree of contact, level of experience, training and supervision also varied dramatically. This variation rendered formal comparison virtually impossible, but does not disqualify the appraisals or conclusions of the review. Rather, it highlights where future research could make improvements.

Recommendations for Future Research

Characteristics of interventions under scrutiny need to be clearly described in future research so that comparisons can be made with other interventions. This is particularly important because 'guided self-help' and 'assisted bibliotherapy' incorporate a diverse range of interventions, modes of delivery and timeframes.

Articles can be extremely unclear about the specifics of the intervention, omitting necessary details such as frequency and duration of contact, nature and content of materials, focus of sessions, training and experience, and amount of supervision received.

The clarity and detail of reporting on attrition was mixed within the studies in the review. Future research could be improved by more precise reporting on aspects of patient throughput and dropout for each time-point and condition, such as the number referred and eligible, attended assessment and intervention sessions, later excluded due to delayed decisions about unsuitability, discontinued with the trial but continued with the intervention, and prematurely disengaged (with reason for disengagement). There was often insufficient clarification about data unavailability, and this issue needs to be addressed more clearly in future research. There are several articles from the CONSORT working group providing advice on how to enhance quality in reporting (e.g., Schulz, Altman & Moher, 2010). Adhering to such guidelines would enable other researchers to scrutinise findings and conclusions more closely.

Detailed consideration of satisfaction and adherence is crucial to research in this field. However, measures are often intervention-specific or loosely described, precluding comparison with other interventions or studies. Adoption of a common set of standardised and validated measures of satisfaction and adherence would be a beneficial addition to guided self-help practice and research, and each group, not just the intervention group, should be evaluated. For satisfaction, a brief, well-established questionnaire akin to the Client Satisfaction Questionnaire (CSQ-8; Attkinsson & Zwick, 1982) could be considered. The issue of measuring adherence is more problematic, as unless there is standardisation in the intervention and procedure, it is difficult to see how a common set of measures for adherence could be adopted. The focus of attention for the reviewed studies was predominantly on global outcome comparisons, with few considering the effects of adherence and

satisfaction on attrition and outcome. No promising themes were identified and future research should examine these links more closely.

Establishing the most appropriate format, for whom and for what presenting problem, is an evident line of inquiry, as is identification of those most likely to engage with and benefit from this type of intervention. Research has indicated a wide-range of individual and systemic influences upon engagement and outcome, such as patient and referrer expectations (Rogers et al., 2004); previous experiences of services (Chapple & Rogers, 1999); and the relationship with the person offering help (Banasiak et al., 2007). Wider societal influences are also worth consideration. Cultural scripts about mental health and what constitutes appropriate treatment transmitted through family attitudes or by the media are likely to have a substantial impact (Ekdawi, Gibbons, Bennett & Hughes, 2000) making this another interesting avenue to explore.

Given the increasingly diverse population of the UK (Office for National Statistics, 2011), it is important to consider how migrant communities and minority ethnic groups perceive guided self-help texts and translations. Liu et al. (2009) highlighted that while a migrant community was able to gain benefit from a translated text, several participants noted that they had difficulty identifying with the cultural backgrounds, experiences and conflicts of the characters presented. The apparent contrast to their dominant narratives and values may have played a role in engagement with and benefit from the materials. Had more culturally relevant examples been incorporated, this may have yielded additional benefit. Assessing the availability and cultural relevance of self-help texts is another important area for investigation.

Economies of scale mean that most mental health services are located in highly populated urban areas, leading to restricted access for rural communities (British Medical Association, 2005). Bilich et al. (2008) outlined their attempt to address this issue in Australia with the use of self-help texts and telephone support,

and reported enhanced outcomes for those receiving support compared to the no-contact group. This could be applied to address the unmet needs of residents of remote areas or those who cannot attend face-to-face support sessions due to restrictions in mobility or transport.

Conclusions

The review questions were deliberately broad and loosely defined: what can we learn about attrition, adherence and satisfaction from efficacy and effectiveness studies, and what links could be made that might inform efforts to enhance outcome. The review found that while satisfaction was high and adherence was generally good, attrition was a consistent problem, and the conclusions presented in the studies under scrutiny were usually based on a minority (predominantly those who had engaged and/ or benefitted); this leaves the review question largely unanswered.

Despite increasing political and economic interest in guided self-help approaches, particularly within the IAPT programme, satisfaction, attrition and adherence are not discussed consistently or comprehensively in outcome studies. Until there are more systematic, prospective studies completed with appropriate comparison groups that also provide sufficient detail on and discussion of these factors, it will be difficult to draw firm conclusions about how they influence outcome. While there is clearly still room for improvement in high-quality outcome research evaluating guided self-help interventions, satisfaction is high for those who have shared their views. Investigation of the views of people who disengaged or held less positive views would be an interesting avenue for future research.

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Part 2: Empirical paper

Barriers to engagement with assisted bibliotherapy in primary care

Abstract

Background: 'Minimal interventions' such as assisted bibliotherapy are increasingly being delivered within primary care services as part of the low-intensity Increasing Access to Psychological Therapies (IAPT) services. Despite its documented success and widespread use, evidence on effectiveness and acceptability is mixed and disengagement is common. Qualitative studies in this area have indicated that recipients can have vague or inaccurate ideas about what is involved, and what is expected may not correspond with what is offered. Given the scale of the programme and the investment, closer scrutiny of factors associated with disengagement and lack of benefit is indicated.

Aims: To explore the views and experiences of people who disengaged or did not benefit from services offering such interventions and consider factors contributing to these outcomes.

Methods: Thirteen participants who attended at least one session of text-based guided self-help for anxiety or depression were interviewed; two more gave accounts by email. Thematic analysis was used to analyse the interview transcripts.

Results: Eight themes were derived relating to participants' expectations and experiences of assisted bibliotherapy. Overall, participants reported viewing the intervention as insufficient to deal with their problem; this related to the materials (e.g., inadequately engaging), the worker (e.g., perceived lack of experience), and the process (e.g., procedure-focused rather than person- or problem-focused). The service was seen as valuable, however, but not the 'right thing for them'.

Conclusions: Effective implementation of low-intensity interventions depends upon clients being provided with information at point of referral that emphasises the core features of assisted bibliotherapy and the differences from traditional psychological therapy. It is also contingent upon workers successfully developing and maintaining a sufficient therapeutic alliance. Clinical implications and future research possibilities are discussed.

Introduction

One in four GP consultations are for mental health problems (Department of Health, 2000); however, primary care is struggling to meet the demand (Farrand, Confue, Byng & Shaw, 2008). Although pharmacotherapy is a frequently chosen treatment in primary care (Richards, Lovell & McEvoy, 2003), many patients do not favour drug treatments and commonly discontinue or do not even start the prescribed course (Hansen et al., 2004).

A number of well-established psychological therapies with demonstrated effectiveness for depression and anxiety offer an alternative to medication (Department of Health, 2001), with Cognitive Behaviour Therapy (CBT) having the most convincing empirical support (National Institute for Clinical Effectiveness, 2004a,b). However, historically there has been poor access to psychological therapy, leading to a large disparity between the proportion of people who want help with these conditions and those being offered such treatments (Lovell & Richards, 2000). As a result, many people do not receive any form of psychological intervention and continue to suffer unnecessarily with mental health difficulties (Bebbington et al., 2000).

To address this gap, guided self-help interventions, where information delivered using books, videos or computer programs plus brief assistance from a mental health professional provide patients with the skills to manage their symptoms, are increasingly being delivered within primary care services with documented success (Gellatly, Bower, Hennessey, Richards & Lovell, 2007). In recent years, they have become an essential part of the low-intensity arm of the Increasing Access to Psychological Therapies (IAPT) programme (Clark, Layard & Smithies, 2009; Farrand, Duncan & Byng, 2007), a multi-million pound government initiative to reduce the personal, social and economic impact of mental health difficulties. With widespread implementation of low-intensity services across the country, there appears to be an assumption that consumers of these services will

view them as acceptable and effective. However, the evidence on effectiveness is far from conclusive (Lovell et al., 2008; Mead et al., 2005; Richards et al., 2003) and ambivalence and disengagement are common (Rogers, Oliver, Bower, Lovell & Richards, 2004). Given the scale of the programme and the investment, this assumption of acceptability deserves further scrutiny.

Qualitative studies on guided self-help indicate that recipients can have vague or inaccurate ideas about what is involved, and that what is expected may not correspond with what is offered. Rogers et al. (2004) reported that several of those interviewed in their evaluation of a self-help clinic (see Lovell, Richards & Bower, 2003) had believed that they would receive formal counselling, a view incorrectly reinforced by their GP. Similarly, Macdonald, Mead, Bower, Richards and Lovell (2007) interviewed people who received guided self-help while on a waiting list for psychological therapy (see Mead et al., 2005) and participants commonly expressed the view that information given by GPs about guided self-help was insufficient. Gaps between patients' expectations and their experience were also noted; for example, people reported expecting to talk about and understand the cause of the problem, whereas the focus of the intervention in question was symptom reduction.

Understandably, much of the literature on guided self-help explores effectiveness or mechanisms of change, such as self-efficacy (Cuijpers, Donker, Van Straten, Li & Andersson, 2010; Gellatly et al., 2007; Rogers, et al., 2004). To ensure that resources from the unprecedented investment in psychological services are used effectively, more also needs to be known about the processes involved when people *disengage* or when the intervention is *unsuccessful* (Macleod, Martinez & Williams, 2009). A number of studies have examined acceptability and satisfaction, but participants have generally been clients who completed or benefitted from such interventions (Rogers, et al., 2004; Banasiak, Paxton & Hay, 2007; Lovell, et al. 2008), and the views and experiences of people who have withdrawn or not benefitted from guided self-help are less well represented.

Research targeting such groups may offer valuable insights on how to improve engagement.

The aim of the current study was, therefore, to explore the experiences of people offered guided self-help, specifically assisted bibliotherapy, within a low-intensity IAPT service, focusing explicitly on those who disengaged or did not find this intervention helpful. Their views on helpfulness, acceptability, credibility and relevance of the intervention were elicited, with the aim of highlighting important factors contributing to decisions about completion or discontinuation. By examining expectations of what would be offered and experiences of what was received, it was hoped that our understanding of service users' perspectives could be enhanced, and insights gained into how such services can be promoted and tailored more effectively.

Qualitative methods offer rich and detailed information and are ideally placed to explore the issues concerned where the views of a population of interest are not known (Crawford, Ghosh & Keen, 2003; Pope & Mays, 1995); consequently, the study employed semi-structured interviews. Thematic analysis (Braun & Clarke, 2006) was used, as it is a flexible and accessible approach, independent from a specific theory or epistemological stance.

Research questions

Given that research to date has not yet specifically focused on those who have withdrawn from text-based guided self-help interventions, the research questions for this study were as follows:

1. What is the experience of people who do not engage with or do not benefit from assisted bibliotherapy?
2. What reasons do they give to account for their disengagement or lack of benefit?

Method

Setting

The research was conducted within a primary care psychological therapies service in an inner-city NHS Foundation Trust. Brief low-intensity interventions were offered by Primary Care Mental Health Workers (from here on referred to as 'workers') within allocated GP practices or community centres. The role, a precursor to the recently introduced 'Low-intensity IAPT Workers' and 'Psychological Wellbeing Practitioners', was introduced in the borough in 2003 and was well established at the time of the research.

Between March 2010 and April 2011, the ethnicity of people using the service was as follows: Asian 4%, Black 8%, Mixed 5%, White 71%, Other/ Not stated 12%, and the gender ratio was roughly 2:1 in favour of women.

Participants

Thirteen participants were interviewed and a further two gave information via email. In total, there were nine women and six men with wide variation across age, ethnic origin, occupation and educational history (see Table 1).

Inclusion and exclusion criteria

Initially, two groups were targeted: those who 'did not engage' and those who 'did not benefit'. To be eligible for either group, potential participants were required to: i) be aged 18 or over, ii) have a conversational understanding of written and spoken English, iii) have attended at least one guided self-help session, and iv) be above clinical threshold on the Generalized Anxiety Disorder scale (GAD-7) (Spitzer, Kroenke, Williams & Lowe, 2006) and the Patient Health Questionnaire (PHQ-9) (Kroenke, Spitzer, & Williams, 2001) at assessment with the worker. Furthermore, the 'did not engage' group were defined as those who had attended one appointment and did not return, and the 'did not benefit' group were defined as those who attended all available sessions, but were deemed not to have gained clinically reliable benefit according to Reliable Change Criteria, as outlined by

Jacobson and Truax (1991); in other words, the difference between their first and last session scores on either outcome measure did not indicate significant reliable reduction and remained above clinical threshold.

The inclusion criteria for the 'did not engage' group were later expanded, as several individuals who had attended two or three sessions expressed an interest in sharing their views, and due to limited uptake, they were interviewed. Their accounts seemed to be more in line with the 'did not engage' group rather than the 'did not benefit' group (as they did not attend all of the available sessions and reported disengaging for similar reasons to people attending only the assessment session), and so were conceptualised as such in the analysis.

Exclusion criteria were: current experience of psychotic symptoms or suicidal ideation, impaired cognitive functioning, alcohol or drug dependency and apparent inability to recall details of the session when prompted during a telephone screening call. Other pragmatic reasons for exclusion, such as on-going treatment, immediate referral to the high-intensity service and lack of permanent address, were applied.

Workers

Of the twenty-three workers in the service, nine had clients who were interviewed. Workers were eight women and one man, mainly in their late twenties (range 25-44), and predominantly White British. All had a first degree in psychology and had completed a post-graduate course in delivering low-intensity CBT interventions. Relevant experience varied from less than one year to over five, the median being four years.

Researchers

The primary research team consisted of myself, a 30-year old female clinical psychology trainee, and my two research supervisors: two male clinical psychologists, one of whom was the acting service manager. The researchers were all White British. My interest in service users' experiences and the use of therapeutic reading materials originated from prior clinical and research experience in these

Table 1: Demographic characteristics of participants

ID	Gender	Age	Ethnicity	Occupational status	Educated to degree level or above	Presenting problem	Sessions attended	GAD 7 at assessment	PHQ 9 at assessment
P1	F	30s	-	-	-	Depression and anxiety	1	14	17
P2	M	40s	-	-	-	Panic attacks, relationship problems	7	18	19
P3	F	20s	White European	Student	No	Anxiety, panic attacks	1	-	-
P4	M	20s	White British	Employed	No	Anger, alcohol abuse	2	16	17
P5	F	20s	White European	Student	Yes	Relationship problems, post-natal depression	1	20	13
P6	F	30s	Black African	Sick leave	Yes	Work-related stress, depression	1	24	14
P7	F	30s	White British	Maternity leave	Yes	Post-natal depression	1	10	16
P8	F	30s	White Other	Employed	Yes	Depression	3	8	4
P9	F	30s	White British	Maternity leave	Yes	Relationship problems, depression	1	12	12
P10	M	30s	White Irish	Sick leave	Yes	Work-related stress, depression	6	4	11
P11	M	30s	White British	Unemployed	No	Depression, panic attacks	1	24	15
P12	F	40s	White British	Unemployed	No	Depression	2	20	20
P13	M	50s	White British	Employed	No	Depression, work-related stress	2	16	16
P14	F	50s	White British	Unemployed	No	Depression	1	21	11
P15	M	50s	White British	Self- employed	Yes	Anxiety, depression	2	13	14

areas. At the start of the research process, my assumption was that reading materials would be viewed as helpful but expectations about the service would be unclear or unrealistic. In accordance with qualitative research procedures, I attempted to 'bracket' these assumptions during data collection and analysis.

Procedure

Intervention

Following service protocol, workers made contact with clients within two weeks of receiving the referral, to discuss their difficulties and arrange an appointment within a further week to six weeks. The initial appointment, lasting between 60 and 90 minutes, was conducted at their surgery or a local mental health centre during office hours. It consisted of an assessment of clients' circumstances and the extent of the difficulties, followed by a brief CBT-based formulation. Symptom-specific booklets were then discussed in-session and clients were advised to do activities listed within. Up to six brief follow-up appointments or calls were then offered to discuss progress.

Recruitment

A consecutive case series sampling method was used. Workers were initially asked to identify potential participants from their caseloads based on the initial eligibility criteria described above. As recruitment was slower than expected, potential participants were subsequently identified by the researcher from an anonymised database, which had details of attendance and scores, with two designated workers who received extra information about the study and on-going support, doing fine-tuned eligibility and risk assessments.

Unless it was deemed clinically inappropriate, the two designated workers sent those who met criteria a leaflet and invitation letter signed by the low-intensity service manager with a brief information leaflet (see Appendices 1 and 2); the researcher's independence from the worker and the service was clearly highlighted in both. Potential participants were asked to return a reply slip (see Appendix 3) to

the researcher in a stamped addressed envelope, which was also enclosed in the invitation pack, to indicate whether they were interested in being contacted and offered further information. To allow those who were unable or reluctant to be interviewed an opportunity to share their views, the reply slip featured a brief questionnaire (indeed, this was completed by several respondents who did not wish to be interviewed).

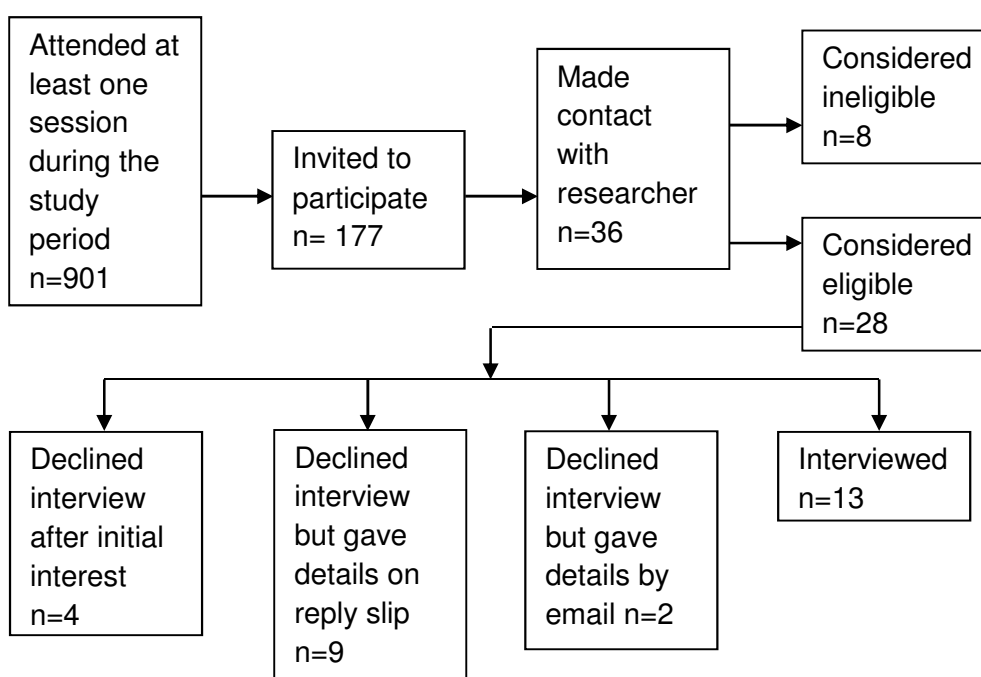
The researcher then called individuals who indicated that they were interested in discussing their experiences and gave further details before arranging an interview. Patient Information Sheets (see Appendix 4) were sent out and participants had an opportunity to ask questions as part of the informed consent process prior to interviews taking place (see Appendix 5). Figure 1 demonstrates the flow of participants during the study period.

Interviews

The interviews took place within a university building or in participants' homes and were digitally recorded with participants' agreement. They lasted approximately 60 minutes and focused on the following topics (see Appendix 6):

- i. briefing on the interview and gaining informed consent
- ii. participants' view of the problems that they wanted help with
- iii. how guided self-help was introduced to them
- iv. expectations of what it would involve and whether it would work for them
- v. how they came to a decision about attending
- vi. their experience of the appointment/s
- vii. their views on the materials
- viii. how they found the interaction with the worker
- ix. their opinions about guided self-help now
- x. ideas about what improvements could be made
- xi. de-briefing on the interview process and future contact

Figure 1: Recruitment statistics



At the start of the interview, participants were encouraged to talk freely and give honest feedback, reminded of the researcher's independence and assured that their responses would not be used against the worker that they saw. The researcher attempted to avoid unduly influencing participant by taking care not to state a position on guided self-help or the service, and checking out meaning where it was unclear.

During the course of the research, the interview schedule was adapted to incorporate themes that seemed to resonate with interviewees (e.g., support provided by non-NHS sources) and to reduce overlap when questions had already been answered (e.g., current views on guided self-help). Interviews were transcribed verbatim and information that could identify participants or workers was removed. Participants were offered £10 to reimburse them for any expenses incurred.

Ethical issues

Ethical approval was obtained from the North West London Research Ethics Committee 2 (see Appendices 7 and 8 for research approvals). A small number of participants became noticeably upset when recounting their experiences, although

none wished to terminate the interview, and most spontaneously reported being pleased to have had an opportunity to share their views.

Analysis

An inductive, data-driven approach (Patton, 2002) was taken to labelling themes. To avoid becoming constrained by prior assumptions, as recommended by Braun and Clarke (2006) when using such an approach, care was taken not to engage with and be influenced by the literature during analysis. I led the analysis, but was assisted by both supervisors who acted as 'analytical auditors' (Elliot, Fisher & Rennie, 1999).

Transcripts were analysed using thematic analysis (Braun & Clarke, 2006) from an essentialist or realist perspective, with the assumption that the accounts given by participants offered a valid representation of their experiences and views. The first step involved reading and re-reading transcripts to develop a comprehensive overview of the data. Careful line-by-line examination then took place and units of meaning, ideas and impressions were noted in the electronic margins (see Appendix 9). These notes were abstracted into 'codes' which were collated into tentative subthemes (see Appendix 10), generated from opinions and experiences that were repeated or stressed, or where comments made were related to the research questions. Additional areas of apparent relevance and importance to participants were also noted. Once all transcripts had undergone the coding and thematic labelling process, related subthemes were grouped together into broader themes. During this process, transcripts were continually reviewed to ensure that they were the driving force in the analysis, and initial themes and subthemes were continually modified and refined. Finally, an organising thematic structure that conveyed the participants' views and experiences was decided upon.

Credibility checks

In accordance with best-practice recommendations for qualitative research (Stiles, 1999; Willig, 2008), efforts were made to enhance the credibility and validity

of the data and analysis. The first supervisor independently read and made notes on the first two transcripts, which were then compared to codes and themes generated by the researcher. Throughout the process, the researcher and first supervisor discussed consistency of coding and representativeness of themes. Upon completion of transcription and thematic labelling for all interviews, the first supervisor read through summaries and assisted the researcher in establishing a set of distinct themes, which were then subject to further redefinition upon close consideration of original transcripts. A penultimate set of well-defined themes and subthemes was organised into a thematic structure prior to comments on this from the second supervisor. Following this, the final thematic structure was completed.

A summary of the salient points and themes from each interview was also sent to the individual participants to establish if, from their point of view, the essence of their account had been accurately represented. They were also asked if there were any themes that deserved particular emphasis, whether any important points had been missed and were invited to make further comment about the guided self-help or the interview if they wished. Ten of the interviewed participants responded and all indicated agreement with the themes; none suggested that a specific theme was missed or should be emphasised.

A small number of workers, from this and other services, were also informally asked about their experience of being a worker, taking part in the study (where relevant) and their opinions on the representativeness and usefulness of the themes. They considered the themes to be highly relevant and representative of their experience.

Results

Non-participants

Nine individuals who returned the reply slip indicated that they did not wish to be interviewed but filled in the brief questionnaire. Of these, five attended only one or two of the sessions and four attended most or all. Respondents were invited to circle

Table 2: *Summary of responses for non-participants*

Item	Frequency
The problem seemed more manageable	5
I wanted to see someone more experienced/ qualified	2
The problem had gone completely	1
I found other ways to deal with the problem	4
My GP did not seem enthusiastic about guided self-help	0
I was referred to a different service	1
I could not attend the appointment	3
The problem had become worse	0
I wanted to see someone for regular therapy sessions	1
I did not think that I could be helped by guided self-help booklets	2
Other (please make any additional comment if you wish)	0

all responses that applied to them, and most circled more than one response (see Table 2). Although there were several responses indicating the perceived insufficiency of what they were offered, around half reported that the problem seemed more manageable or had found other ways to cope, and a third reported finding it difficult to attend. One respondent indicated that the problem had gone completely and none of the respondents indicated that the GP was not enthusiastic or that the problem had got worse.

Participants

Fifteen respondents gave detailed information about their experiences; thirteen via interview and two via email. Participants were all able to recall their interaction with the worker and their views about the booklets, and appeared to offer their opinions, positive and negative, freely and with minimal prompting. Initially, the results from those who disengaged and those who engaged but did not benefit were intended to be presented separately, but due to limited response from individuals who had attended all of the offered sessions, and the similarity of responses across interviewees, no distinction has been made. From participant reports, eight themes were generated about their views of guided self-help, the service they received and the factors that influenced their disengagement or lack of benefit (see Table 3). These themes revolved around the gap between expectation and experience, the

Table 3: Themes and subthemes

Themes and subthemes	Frequency ¹
1. <i>It's good to talk</i>	General
a) Talking makes me feel better	Variant
b) Talking as a vehicle for change	Typical
c) Therapeutic talking with professionals	Variant
d) Taboo and stigma as barriers to talking	Variant
2. <i>This wasn't what I expected/ wanted</i>	General
a) GP didn't/couldn't give me an accurate impression of the service	Typical
b) I expected/ wanted more talking	Typical
c) I expected/ wanted to see someone more qualified	Variant
d) I expected/ wanted someone older	Variant
3. <i>This wasn't enough to work for me</i>	General
a) The booklets didn't tell me anything new	Typical
b) I didn't notice any real difference	Typical
c) This is too simplistic and so is of limited use	Typical
d) My problems were too severe for this or got in the way	Typical
e) Negative reactions to the booklets, questionnaires or process	Typical
f) I didn't 'get it'	Variant
4. <i>This should have been more about me</i>	Typical
a) The formulaic format missed me as a 'whole person'	Typical
b) It was too focused on the questionnaires/ booklets and not me	Variant
c) One size doesn't fit all	Variant
5. <i>S/he didn't understand</i>	General
a) S/he wasn't tuned in to me	Typical
b) Limited work experience	Typical
c) Lacking in life experience	Rare
6. <i>I couldn't put my trust in him/her</i>	Typical
a) S/he didn't create a safe space for me to talk	Variant
b) Inflated perceptions of youth	Typical
c) S/he was using me to gain experience	Variant
d) Importance of specialist knowledge	Typical
e) Lacking the authority to act	Variant
7. <i>I found other ways of coping</i>	General
a) The problem became more manageable	Typical
b) Medication	Typical
c) Support from family and friends	Typical
d) Doing things differently	Variant
e) Accessing other services and alternative treatments	Variant
f) Keeping busy	Typical
8. <i>Valuing the service</i>	General
a) A good service, but it just wasn't what I needed/ wanted at the time	Typical
b) Normalising and reinforcing advice	Typical
c) There has been some change	Variant
d) Caring, consistent and efficient	General

¹ As these accounts were briefer, the points made by email were not included in the count. General = applies to all or all but one of the participants (12 to 13); Typical = applies to more than half of the participants (7 to 11); Variant = applies to up to half of participants (3 to 6); Rare = applies to one or two of the participants (1 to 2)

perceived insufficiency of the intervention and alternative means of coping. Broad frequencies are given to indicate the regularity of themes, but exact counts are not given, as this would give a false exactness to an imprecise and subjective process.

Relevant context

Sixty per cent of the participants had had at least one session of counselling or therapy to address mental health difficulties with an NHS or private practitioner, and for some this was long-term therapy. There was a mix of expectations about the nature and outcome of the intervention, which did not seem to be dependent on prior experience of mental health services. Around half of the participants discussed the period between referral and assessment, which for these participants ranged from between two weeks and two months. Most individuals had been in regular contact with their GP prior to the referral.

Presentation of themes

1. It's good to talk

Participants expressed the view that “it’s good to talk” and this appeared to influence their view of what would help them to deal with their difficulties. This in turn affected their perception of guided self-help and their subsequent engagement.

a) Talking makes me feel better

Several participants spoke of the value of “getting things off their chest” and of the relief they experienced from talking. Of similar importance was talking to “get things clear in your mind”, which was considered to reduce distress and make life easier to manage. For some participants, talking about problems was a preventative measure, as they had witnessed or experienced the negative effects of *not* talking (e.g., depression and distress in family members). The importance of feeling like someone was there for them was also stressed, and talking was experienced as being therapeutic even if the distressing situation they were facing remained unchanged.

Sometimes it's just good to talk about these things even if you don't get a solution, but just to tell someone. [P3, female]

b) Talking as a vehicle for change

Although talking was described as difficult or distressing at times, it was ultimately considered helpful, as it often brought about understanding, acceptance or change. Participants spoke about how talking about their concerns helped them to discover something new or get a different perspective. One participant, who had fifteen-minute telephone follow-ups after the initial guided self-help assessment, described the contrast between this and face-to-face sessions that he subsequently received with a different service.

Because that was all face-to-face, we would sit and do it ... Then I had the chance to ask any questions about it. Also to discuss what I felt like, if I felt it was helpful. Whereas if you compare that to the booklet, if I read this is how you do the breathing exercise, I might try it then I might think "well, am I doing it right or not?" I probably wouldn't stick with it for five minutes and then I'd probably just give up with it. [P10, male]

c) Therapeutic talking with professionals

Conversations with friends and family were often seen as supportive, but not unanimously, as sometimes participants felt misunderstood or judged. As a result, conversations with professionals, who were sympathetic "outsiders" from the family, were widely viewed as positive. Many participants had engaged in therapy in the past and this was largely viewed as helpful.

I think because I've had positive experiences and constructive experiences with counselling in the past, I thought, well I am feeling a bit better, but it's worth a go to see if, you know, this might help a bit more, because I still was not feeling hundred per cent. [P7, female]

d) Taboo and stigma as a barrier to talking

Some participants also talked about how taboo and stigma surrounding mental health problems prevented them from talking about their situation. This obstructed recovery and exacerbated the problem.

So I remember telling my friends that I was really depressed. And they would say, "What's wrong with you? Have you got Aids?" So I would be like, "no", and they would say, "Well, what's wrong? What have you got to be depressed about?" And that made me feel really stupid. [P6, female]

2. This wasn't what I expected/ wanted

Although participants' descriptions of what they thought they were being offered or what would help were often vague, several indicated that they expected something more in line with counselling or conventional therapy.

a) GP didn't/couldn't give me an accurate impression

Several participants felt that their GP did not give them an accurate impression of the service. For some, this was because they believed that their GP was not acquainted with the relevant details, while others thought that their GP did not have time to elaborate. Some participants were aware that they were being offered a brief intervention rather than long-term therapy; however, others reported that the conversation with their GP led them to believe that they were being offered something more substantial than guided self-help.

[The GP] said that it was just counselling really. I would see someone who would help me for six sessions or something like that. It was just counselling as far as I remember. [P6, female]

b) I expected/ wanted more talking

Furthermore, participants expected the sessions to involve more talking and thought that the worker would help them to explore and resolve the difficult feelings or situation that they were experiencing. Essentially, participants anticipated that "you go, you talk, and they discover the root of your problem", but for many the format was contrary to expectations.

I guess I expected just going and talking to somebody. It'd probably be longer term... I just thought that I will see somebody face-to-face, generally weekly, so probably about right in terms of getting regular contact, and you get a bit of time to process things in between. [P10, male]

c) I expected/ wanted to see someone more qualified

A frequently noted expectation from participants, particularly those who were presenting in crisis, was that they would be seen by someone with specialist knowledge of their problem. This often led to disappointment and disengagement.

I hoped that I would talk to a psychiatrist or a neurologist and they would know my situation and they would be able to help me quickly if I needed help. I was looking for quick and effective access to a specialist...My expectations were probably high in terms of her/his qualifications, while s/he's nice and very helpful, s/he's not exactly a psychiatrist or a doctor and this is why eventually I stopped going there [P8, female]

d) *I expected someone older*

There was an expectation from a number of participants that the worker would be "someone older". This was expressed explicitly, with descriptions of a "Freudian old [man], sitting there stroking [his] beard", or implicitly with comments like "in most therapies, people enter [the job] quite late in life".

I don't know how old s/he was, maybe twenty or so, but you have an idea. You get a picture in your head of like a middle-aged woman or man and then it turns out to be a young girl/boy. [P13, male]

Perceptions of age and age gaps were often talked about and this point is elaborated upon in a later theme.

3. This wasn't enough to work for me

A feeling that the booklets and sessions with the worker were insufficient to deal with the difficulties that participants were facing permeated all of the accounts; as one participant put it: "it was a bit like ordering Champagne and getting flat lemonade".

a) *The booklets didn't tell me anything new*

Many participants did not consider the booklets to be helpful because, in their view, much of the descriptive material on what they were experiencing and possible coping strategies did not seem to offer relevant, new information about how to manage the problem. For some, the booklets seemed to be stating the obvious, and the overall view was that information about how to gain the momentum and motivation to apply those ideas was lacking.

It didn't even tell me anything new...I know that if you get up and do things you feel better but it didn't address that hurdle of how you get up and do things. There wasn't a push, you know. There wasn't anything in it that made me want to get up. [P14, female]

Others reported that they did not gain much from the booklets because they did not read them. Reasons for this included not understanding the language and not having the required concentration or motivation.

My one main concern about the sessions was the amount of reading involved. When you're feeling low and your concentration is not what it should be, it could sometimes be a struggle to comprehend. [P2, male, email]

b) I didn't notice any real difference

Another consistent reason for disengaging from sessions was perceived lack of benefit. Participants had expected to notice some change in how they were feeling and when this did not happen, in some cases after several sessions, they did not believe that it was worth continuing.

I was hoping for something at least. I wasn't hoping for a cure, you know, walking home without any panic attacks, but something. And I didn't get anything. [P3, female]

c) This is too simplistic and so is of limited use

Many participants' indicated that they thought that the information in the booklets was "simplistic" or "too general", and underestimated the problem that they were facing. This criticism was also explicitly laid at the IAPT programme and CBT more generally. The intervention was considered to be superficial and of limited use because, "it's not solving what's actually happening for you".

I'm not a great fan of CBT. I know it's flavour-of-the-month and that it's been offered widely... It's not based on the person, it's abstracted on the person and it takes situations- "You're in this situation, how do you feel? Can you feel differently?" It's just – it's very limited, I think. [P15, male]

I have to say, I did feel incredibly let down by this service, but I also don't see the point in it. Really, you should be treating the cause, not the symptom, and in my mind guided self-help is just a way of putting a plaster over a wound. [P1, female, email]

d) My problems were too severe for this or got in the way

Linked to this, a consistent view expressed by participants was that they did not believe that what they were offered was appropriately matched to the severity or complexity of the problems they faced. Participants perceived the guided self-help

as a weak substitute for what they really needed and the problem often interfered with completing suggested tasks. There was also disappointment about the brevity of the sessions and doubt about the likely success.

To be honest, the reason I did not attend a second session is because it was the wrong course of treatment for me, and a better solution was not forthcoming. I needed to see a counsellor, not some silly book which tells me to breathe deeply! [P1, female, email]

e) Negative reactions to booklets, questionnaires or the process

Several participants reported having strong negative reactions to certain aspects of the materials and sessions. Filling in “tedious” questionnaires that were “of no use to man nor beast”, being “fobbed off” with “boring” booklets and drawing “funny” formulation diagrams led participants to feel “hostile”, “annoyed”, “patronised” and “irritated”, which ultimately resulted in disengagement.

I started to fill them in then I thought I can't be bothered to answer any more questions. I think the questions were closely related and then it was asked again and it felt like you'd already answered a particular question, and then it was asked again in a slightly different format. That irritated me as well. [P15, male]

f) I didn't get it

A small number of participants reported confusion about the point of the sessions and content of the booklets. Despite workers attempts to explain, these participants did not see how they could do the activities or understand how they would help.

I didn't really understand what it was trying to say. Well [it was about], trying to think differently. I couldn't really get my head around it. [P13, male]

4. This should have been more about me

A common view was that the worker should have been more focused on talking about them and less focused on paperwork. For these participants, there was an overriding sense that forms and questionnaires “took over” at their expense.

a) The formulaic format missed me as a ‘whole person’

Sessions were viewed as “formulaic”, “mechanical” and “impersonal”; occasionally this was attributed to the worker’s lack of skill, but largely it was

considered to be a consequence of the format of intervention itself. Overall, it left participants feeling like they were being “processed” and “not seen”.

It did feel that I was going through a process and it was like a formula. It did feel a bit cold in a sense, particularly with the two forms you fill in for every session, with questions on them and you rate how you're feeling. That really does give it a sense of, you know, being a formula. [P10, male]

b) It was all about the questionnaires and booklets, not me

Participants spoke of their disappointment and annoyance that the focus of the session/s seemed to be predominantly on the self-help booklets and questionnaires rather than them. Questionnaires were viewed as a distraction from the limited time participants had to talk about what they thought was important.

S/he also would not go into my specific problem and I had to say a couple of times, “yeah, but that's, that's what it says here but that's not, it's not me, you know”... It was more about the book than about me. [P3, female]

c) One size doesn't fit all

When workers did not ask about or show an interest in participants' views on the problem, and instead continued with their “pre-programmed questions”, this led to a sense that the workers were not adaptive to individual circumstances and triggers. It seemed like a “one size fits all” model which was not tailored to them.

S/he assumed it was like having a broken leg, and so everybody's leg gets treated the same. [P14, female]

5. S/he didn't understand

Participants reported wanting to understand and be understood; overall, this did not materialise. Workers were not considered to be sufficiently experienced or attentive to understand or deal with the problem effectively.

a) S/he wasn't tuned in to me

Participants expressed the belief that the worker was not ‘tuned in’ to them and thus did not understand the problem. A rarely expressed point of view was that cultural difference would preclude the worker from being able to understand. However, the majority felt that the worker simply underestimated the problem and the consequences.

S/he was trying her/his best, but I felt deep down that s/he probably didn't understand the seriousness of what I do. [P4, male]

b) Limited work experience

The preceding point links with participants' belief that workers had limited training and/ or experience. Participants believed that workers had only "theoretical knowledge but not really practical experience or understanding" and that their knowledge was limited to what was featured in the booklets. This opinion was formed not only on *what* workers said but also on *how* they said it.

S/he read from the booklets rather than talking to me from her/her own knowledge didn't make me feel confident that s/he knew what s/he was talking about, although that may be practice, but it slightly looked - especially when s/he was doing it on post-natal thing, and it's a specific type of depression- but it did look a bit like... s/he wasn't sure. [P7, female]

c) Lacking in life experience

Alongside the concerns participants had about workers' limited ability to understand them due to restricted work experience, for a small number of participants there was also a sense, particularly when there were differences in gender, that workers would be lacking in *life* experience. Occasionally this led to hostility, but mainly resulted in resignation.

How can a young girl/boy, of that age, understand what I'm gonna tell her/him?...I'm not taking anything away from her/him. If s/he wasn't qualified, s/he wouldn't be there. But yeah basically I think how can someone [her/his age] understand what I'm going through? [P13, male]

6. I couldn't put my trust in her/him

The accounts highlighted the importance of having a sense that the person sat in front of you was had the skills and abilities to help. Many participants indicated that the worker's skills and role were not clear to them; this, and other factors, created unease and ambiguity, which ultimately restricted their ability to talk freely.

a) S/he didn't create a safe space for me to talk

Participants wanted to feel that someone was focused on supporting and 'containing' them. While several participants reported that the worker they saw "tried

their best”, there was a sense that workers were too nervous or too focused on the questionnaires and the booklets to create a safe space where they felt able to talk.

There was no- it's great you've come here, how does it feel to be here?- there wasn't much. It's about setting a safe space, and it didn't feel like a safe space. [P9, female]

b) Inflated perceptions of youth

Workers were in their mid- to late-twenties or above, but some participants perceived workers to be strikingly “young”, with descriptors such as “girl”, “boy” and “kid”. This perceived age difference was “off-putting”, and was not discussed during the sessions. Participants reported finding it difficult to talk openly or feeling the need to “hold back” to protect the worker from being exposed to a situation that they could not manage.

S/he was really lovely, but s/he was- I know it sounds horrible, but I'm forty, and s/he was so young...it did throw me that s/he was so young...I'm not old, but I did feel- I found it difficult talking to her/him. [P12, female]

c) S/he was using me to gain experience

Although not always explicitly stated, an implicit theme across some of the accounts was the sense that because workers were considered to be at the start of their career, participants were almost like ‘guinea pigs’ helping workers to gain experience. While there was recognition that “people have got to start somewhere”, the insinuation was that participants felt like they were ‘carrying’ the worker or foregoing what they needed.

I felt that s/he was using me as much for experience as anything. S/he must have been new to the job, s/he was young, and s/he can't have been out of university that long. S/he was good, s/he was very intelligent and I don't want to detract from her/him, but I felt that they are using people on their way up for their jobs to gain experience. It certainly felt that way to me. [P11, male]

I don't want to be ageist, but I must have been a good ten, fifteen years older than her/him. S/he couldn't have been more than 24, 25, but s/he was definitely right out of college. Obviously people have got to start somewhere, but I think I thought well, I'm getting it for free so what am I expecting. [P9, female]

d) Importance of specialist knowledge

Predictably, specialist knowledge was highly regarded. Participants stressed the importance of specialist knowledge and expertise - in creating a sense of safety and containment, asking pertinent questions, taking the lead, and understanding the problem and how to overcome it. For many, this was not how they experienced the worker.

If you want good treatment, you need someone with good qualifications... I love to have people who I can sense have experience and knowledge and that's usually people who are a bit older, you know. I can't really describe anything in particular about her/him, but I could just sense that s/he did not have the experience. [P3, female]

I just don't feel as if s/he opened up anything with me. S/he made me sort of shut down a bit more...it was sort of up to me to take the lead and I didn't know how to do it. [P12, female]

Participants also spoke of the value of specialist mental health knowledge at the point of referral by the GP. One suggested that psychiatric nurses should be available in surgeries and others said that had their GP referred them to a specialist from the outset, their problems would have been resolved.

e) Lacking the authority to act

Participants placed a high importance on professionals involved in their care being able to protect them from difficult feelings or their own actions. A frequently held view was that the worker lacked the authority to make decisions and give advice, and was unable to respond swiftly to an emergency.

Someone who can make decisions, a primary care mental health worker cannot make decisions. S/he can listen to you and s/he can give you a leaflet, but s/he cannot help you actively. S/he's just there to be there, to listen, which is all very helpful, but you're sick! You don't know what the hell's wrong with you. You want a surgeon to cut out whatever's wrong, and you're getting a homeopath! I hoped that I would talk to a psychiatrist or a neurologist and they would know my situation and they would be able to help me quickly if I needed help. [P8, female]

7. I found other ways of coping

For many, the problems seemed more manageable at the time of interview and alternative ways of dealing with the problem were reported, such as keeping busy, support from friends and family and use of other services.

a) *The problem became more manageable*

Several participants reported that the immediate crisis that led to the referral had abated by the time they saw the worker, but they still wanted help. While a small number did not require any further assistance after the sessions, most still felt that specialist help was required to shift the problem, although few had pursued this.

I knew I would have to wait three weeks and I made a lot of progress on my own in these three weeks because of the gym and the course [at university].
[P5, female]

b) *Medication*

Several participants took medication prescribed by their GP, which was, overall, thought to be beneficial. Some participants reported that it reduced their anxiety and others said that it made day-to-day functioning easier. However, it was also described as giving a “false reality” and most did not want to take medication permanently.

The medication helps a great deal. I don't really want to be on them forever, and that was one of the reasons why I went to this thing. [P13, male]

c) *Support from friends and family*

Several participants spoke of the importance of support from friends and family in helping them to cope with their situation. They appreciated how friends and family “stood by [them]” and acted as a “security blanket” through hard times.

They actually sit down and talk through everything and offer a bit of advice on what they can do to help. Sometimes it benefits, sometimes it doesn't.
[P4, male]

d) *Doing things differently*

Participants spoke about how they had reflected upon their situation and considered what seemed to make things better or worse, and spoke about how this had led them to try to do things differently. Some talked about developing and maintaining a routine, others were focused on changing their way of responding when things become difficult and others tried to improve mental health by improving physical health.

To me, that has been the biggest breakthrough; physical exercise and improving my diet, eating more fruit and vegetables. It's just so good. [P5, female]

e) Accessing other services and alternative treatments

Other services were highlighted as providing, at least in part, what was hoped for when participants initially went to their GP for help. The issues that these services dealt with included resolving conflicts with employers, managing debt, benefit or housing issues, or brief counselling.

Participant: I think (name) from (service) was doing something more constructive.

Interviewer: So it was a little bit more in line with "try this, try that, I can do this if you want it"?

P: Yeah, s/he was more interested in going, "If that's one of the problems, I'll try and get it out of the way for you."

I: So it seemed a bit more practical?

P: More direct help. [P13, male]

Alternative treatments, such as acupuncture, massage and reflexology were also mentioned by a small number of participants as a preferred way of coping with their problems.

I have to give credit to my acupuncturist. I never really believed in that before but it really helped me this year when I was at my lowest. [P5, female]

f) Keeping busy

A commonly used way of coping was distraction or immersion in a hobby. The importance of scheduling time for pleasant things was emphasised due to the positive effects on mood. Similarly, two people who had not worked for a considerable time spoke of their wish to enter into training and secure a job as a way to occupy their time and gain a sense of purpose.

I cook. It's a passion of mine. That is my little world away. I can spend two or three hours easily and not think about anything else. I've not got a care in the world. So I'm trying to just do things all the time. [P11, male]

I decided what I needed to do. I needed to sort of – yeah, it's a behavioural, motivational thing as well – I need to get a job and get out there. [P14, female]

8. Valuing the service

There was widespread acknowledgment that the criticisms offered were “just [their] opinion” and that others may have found the service more helpful. Despite the criticisms, the service was seen by several participants as worthwhile.

a) A good service, but not what I wanted/ needed at the time

Although participants did not necessarily receive what they wanted from the service, they appreciated its existence nonetheless. Some indicated that “it just wasn't the right thing for me” or was “the wrong time”, while others thought that “it just needs maturing and refining”.

I was looking through the materials that s/he gave me later. They were clearly written, simple sentences, bullet points, very easy to understand even in the state I was in. So, yes, the service is valuable, it just wasn't the one I needed. I needed to put the house fire out, not worry about the frying pan. [P8, female]

I appreciate the fact that it was there. I wouldn't not want it to be there. I wouldn't want the research to say that this is useless and therefore we're going to get rid of the service. It irritated me, and that probably had more to do with me than the service. [P15, male]

b) Normalising and reinforcing advice

Several participants noted that they had referred back to the information given to them during the sessions at least once, indicating that perhaps some aspects were seen as helpful. Although the booklets were frequently seen as offering scant original information, if you “picked out the bits that were right for you, it was good”. Indeed, there were reports that the booklets and sessions had a normalising effect and helped participants to feel like “they were not the only one” and were not “going mad”. They were also seen as a useful confirmation of the appropriateness of the strategies that people were already using.

It reinforced to me that what I was already thinking about doing- in terms of making sure that every day I has some things to do, and every week I had some bigger, nicer, aside from the daily stuff, things to do- you know, that it was actually a good way forward. [P7, female]

c) There has been some change

For several participants, life was easier to manage at the time of interview. Numerous explanations were proposed for this change, and a small number of participants made explicit reference to the influence of the sessions.

Actually, I think that if I didn't have the sessions, I probably would have been worse, but since I did I feel that things have actually improved a bit. [P4, male]

d) *Caring, consistent and efficient*

There were positive descriptions of workers being “caring”, “helpful” and “understanding”, offering welcome praise and reassurance, and recommendations on books and other avenues of help. Participants also described workers and the process as “efficient” and “consistent”. For some this had negative connotations of being “processed”, as discussed above, but for others, this perception of reliability helped to foster trust.

I found the sessions with (worker) helpful, meeting her/him once every two weeks or so would give me a chance to express myself, calmly and in a non-judgmental environment. I also found it helpful using (worker) as a sounding board to get my problems and worries out and into the open. It would also calm me down a little bit until the next session. [P2, male, email]

Discussion

The aim of the study was to explore the experiences and opinions of people who had disengaged or had not benefitted from assisted bibliotherapy, and to learn about what factors may be influential in this. Using thematic analysis, eight themes were developed around the influence of expectations and experience of the worker, the booklets and the process. As the focus was on people who experienced what could be described as an ‘unsatisfactory’ outcome (i.e., did not engage and/ or did not benefit), the findings mainly reveal negative opinions, although not exclusively so. It is worth bearing in mind that this is clearly not a reflection of the service as whole, as many others will have experienced a satisfactory outcome. Indeed, the opinions documented here are not necessarily representative of all those who

experienced an unsatisfactory outcome; however, they offer valuable insights into the potential range of reactions that dissatisfied clients may have.

An overall view expressed by participants was that they were unclear about the nature of the service and that they were expecting something different, which in several cases was explicitly labelled as counselling or therapy. Around two thirds of participants had had at least one prior encounter with a mental health professional, and for some this was long-term therapy. One may assume that despite the brief nature of the intervention supposedly explained at referral and prior to assessment, this experience would have some influence on their expectations of the intervention being offered. A mix of expectations were found across all participants (some accurate, most not) regardless of prior experience of mental health services but, interestingly, prior experience did not seem to have a marked effect on expectations in this sample. However, it would be premature to conclude that prior experience plays an insignificant role, and further research in this area would offer valuable insights into its influence on expectation.

In addition to the mismatch in expectations, assisted bibliotherapy was seen as insufficient to address their problems at the time. Participants' doubt about the credibility and potency of the intervention led to disengagement and lack of benefit. Perceptions of the worker, the materials or the process were strong influences in disengagement and lack of benefit, as at least one, sometimes all, were viewed as inadequate or inappropriate for the problem at hand.

Most participants had been in regular contact with their GP prior to the referral, and it seemed that for all, the gradual build-up of distress and interference prior to the visit that precipitated the referral was too much to bear. This 'crisis' moment came with the expectation that something would be offered almost immediately. The period between referral and assessment was discussed and seemed to be important for around half of the participants, which for these participants ranged from between two weeks and two months. Some participants

said that during the weeks between referral and assessment, the problem had partially diminished, but all participants felt at the time that the problem still warranted professional intervention. Lack of noticeable change was also a commonly identified trigger for drop out, regardless of the number of sessions attended. Subsequent to disengaging, many respondents had found other ways of coping and reported at the interview that the problem was more manageable. Alternative treatments (e.g., reflexology and acupuncture) and other services (e.g., debt management and marriage counselling), as well as support from friends and family, keeping busy and paying attention to physical health, had led to at least partial success in tackling the problem.

Participants found other ways of coping/ sources of support seemed to be mainly after, not before the session with the worker. A small number of participants were disappointed by the wait and sought other solutions or sources of support (e.g., acupuncture). However, most, whether unperturbed or otherwise with the delay, did not do anything differently or seek out other ways of managing during the period between referral and assessment. Conversely, after disengagement from one or more sessions, participants were more inclined to actively seek out other ways of coping, but many still felt that there was a problem that needed professional attention.

On three occasions, the worker identified an alternative source of support which they thought might be more useful in addressing the problem (e.g., marriage counselling). This was welcomed in one case, regarded as a dismissal or rejection in another (although the service was helpful), and still waiting in the other (GSH was still available but unwanted). For all cases, this reinforced the perception of insufficiency of the intervention for the presenting problem (which may well be an accurate perception).

Although participants did not think that the service was right for them, they thought that it had some value and that it might be right for others. Despite

disengaging, all participants indicated that the service was worthwhile and some participants said that, on reflection, the session/s had directly benefitted them. On the whole, participants also thought that workers were caring and efficient, and several participants reported that talking with the worker and reading the booklets reinforced their coping strategies or reassured them that they were “not going mad” and were “not the only one”.

Overall, the findings correspond with those of previous qualitative studies of text-based guided self-help. For example, in their study featuring assistant psychologists of a similar age and level of experience to the present study, Macdonald et al. (2007) also documented perceptions of workers as young and inexperienced; limited motivation to read the booklets, and; disappointment at the brevity of the intervention and the focus on symptom reduction rather than cause. However, an important difference is that their sample mainly comprised of people who had benefited or completed the intervention and the impact of the above influences seemed less strong in Macdonald’s trial (e.g., only a minority reported a desire to see a therapist with more expertise and the initial discomfort about age apparently did not endure). Nevertheless, it is of interest that similar themes were expressed.

Rogers et al. (2004) also interviewed people who had received assisted bibliotherapy, on this occasion from an experienced CBT nurse therapist and, as with the present study, they found that many did not know what to expect, or had expectations of formal therapy. They reported that aspects of preceding GP consultations had not provided clients with adequate preparation for their role as the principal driver of change in self-help. Research has also highlighted that inappropriate referrals are often made (Farrand, Duncan & Byng, 2007; Fletcher, Gavin, Harkness & Gask, 2008), indicating ambiguity about the nature and scope of such services on the part of the GP. Opinions expressed by those who have

attended these services underline the importance of appropriate preparation and development of realistic expectations, for both clients and referrers.

Participants' views can be understood in the context of two influential factors relevant to all psychotherapeutic interventions: i) expectations about the intervention and outcome, and ii) the development of a therapeutic alliance. In the current study, participants reported expectations of process and outcome that were often unclear, and there was a mismatch between what was expected, however vaguely, and what was offered. Participants expected the intervention to be more intensive, anticipated the worker having more expertise, and assumed that there would be more discussion about the cause of the problem, rather than a focus on self-management. The expectation of counselling is common and has been highlighted in previous research (Lovell et al 2008; Macdonald et al. 2007; Rogers et al. 2004), suggesting that it is a potential barrier to success that needs to be addressed.

While the importance of talking to someone and problem-exploration are often emphasised by those seeking help, the undertaking of a more 'therapeutic' type role is reportedly beyond the remit of low-intensity workers who are there to 'support' rather than actually 'deliver' minimal interventions (Richards et al., 2002, 2003). Rogers et al. (2004) speculated that patients with expectations of formal therapy may react negatively to minimal interventions leading to drop out. This appears to be borne out in the present study, and supports Lovell, Bee, Richards and Kendall's (2003) assertion that clients need accurate information from GPs to ensure that the purpose of guided self-help is clear.

Therapeutic alliance is regarded as an essential factor in therapeutic change (Gilbert & Leahy, 2009; Roth & Fonagy, 2005). The significance of this construct in therapy has been highlighted in meta-analyses that have found a moderate but consistent relationship between therapeutic relationship and outcome across different types of treatment (Hovarth & Symonds, 1991; Martin, Garske & Davis, 2000). Various aspects of the professional-patient relationship have been identified

as important in developing a therapeutic alliance, particularly the patient's perception of the relevance and potency of interventions offered and their perception of the person offering it (Roth & Fonagy, 2005). While little is known about the impact of therapeutic alliance for minimal interventions where the focus is on the materials and symptom reduction, rather than the relationship (Rogers et al., 2004), as this study demonstrates, the above factors clearly play significant roles.

Lovell et al. (2006) reported that where therapeutic alliances existed, they were highly valued by participants and regarded as an important component in recovery. It would appear that as with traditional psychotherapy, success relies at least in part on a good therapeutic alliance, and disengagement and lack of benefit result at least in part from a poor therapeutic alliance. Cuijpers et al., (2010) suggested that therapeutic alliance can be realised with minimal contact, and that the quality rather than the intensity of the contact is important. Glasman, Finlay and Brock (2004) reported that the development of an effective therapeutic alliance had a positive effect on patients' subsequent use of self-help materials, and it could be argued that an insufficient therapeutic alliance contributed to minimal use of the materials described by the participants here.

Perceived relevance and potency of self-help materials also undoubtedly affected participants' decision to disengage. Previous studies have highlighted similar doubts about the value and relevance of self-help materials, demonstrated by low uptake or participant report (Bower et al., 2001; Cuijpers et al, 2010; McKenna, Hevey & Martin, 2010) and the negative influence of limited concentration and motivation associated with low mood and anxiety on use of and benefit from reading materials (Cuijpers et al., 2007). Bansiak et al. (2007) reported that participants attributed disengagement from guided self-help to lack of noticeable change, an attribution shared by some participants in the present study, which lends further support to the idea that lack of perceived potency leads to disengagement with minimal interventions. It may be that participants simply failed to engage for long

enough to benefit, but offering low-intensity interventions to people unlikely to engage or benefit, for whatever reason, may be counterproductive if future help-seeking is inhibited (Bansiak et al., 2007; Bower and Gilbody, 2005), and as such, it is an issue that deserves further investigation.

Thematically, the accounts presented here overlap with accounts from prior qualitative research in this area featuring participants who engaged (had positive or neutral outcomes); however, it appears that the number and strength of negative opinions is far greater for those who disengaged (or could be defined as having a negative outcome). A tentative model that may be useful in helping us to understand disengagement and lack of benefit is thinking in terms of a 'threshold' and/ or 'continuum' of perceived limitations. If the number of perceived limitations of the intervention (incorporating the worker, booklets or process) reaches a threshold above which a client does not wish to continue, and/ or the gap between what was expected and what was experienced reached a sufficient point on a continuum, disengagement will follow. As the number of limitations increases, confidence in the intervention as 'the solution to the problem' decreases and, likewise, the more difficult it becomes to develop and maintain a therapeutic alliance. Perhaps for people who disengage the limitations are seen as too many, or the gap between expectation and experience seen as too great, for it to be worth their while continuing. Ultimately, this leads to drop out if these perceived limitations are not addressed before reaching the threshold or point on a continuum.

Methodological limitations

Although the principal aim of qualitative research is to generate ideas rather than to generalise findings (Willig, 2008), it is still important to consider how findings may relate to the wider population who use guided self-help services. Therefore, the factors that limit the representativeness of the sample should be considered.

An important point to consider is the nature of the sample. Participants were self-selected and sufficiently motivated to offer their views. It should be highlighted

that although non-participants probably hold similar but diluted versions of the views reported here, the content and strength of opinions presented are likely to be somewhat unrepresentative of non-participants. Respondents had sufficient time and motivation to take part; those with less flexible commitments or reduced motivation may hold different or weaker views. Likewise, individual and systemic factors that prevented people from attending an interview, such as childcare or transportation problems, may have prevented them from attending guided self-help sessions (as indicated by those who filled in the questionnaire on the reply slip), and thus such factors were not highlighted in this study.

As the research focused on experiences and views of participants from one London borough, and views and experiences of a number of groups are absent from this study, generalisations to other services and populations can only be made tentatively. Furthermore, while the sample size is adequate for qualitative research (Willig, 2008), it represents only 8% of those invited to take part and cannot be presumed to be representative of the majority who did *not* take part. Nonetheless, similar studies investigating patient experience of minimal interventions have low response rates (e.g., 14% for Rogers et al., 2004), and as Lovell et al. (2008) suggested, patients who fail to engage are likely to be more difficult to recruit for further research.

Although the study benefits from a broad age range and gender mix, black and ethnic minority groups are under-represented. This may be due to the small sample; however, it is also possible that members of these groups were less inclined to take part. It is possible that the sample is skewed in relation to level of education, as half of the participants were educated to university level, and while the Department for Business and Skills (2011) reports that around 40% of working age adults in London hold a qualification equivalent to degree level or above, it was not possible to establish whether this was representative of the borough or those using the service.

A further limitation is the dependence upon participants' retrospective recall, a potential source of bias (Giorgi & Giorgi, 2003) which may have been enhanced by an unfavourable outcome (i.e., disengagement or lack of benefit from the intervention). Equally, socially desirable responding (i.e., wanting to protect themselves or the worker from negative judgments), or ideas about how data may be used and who might see it could have influenced participants' accounts; however, this did not appear to prevent participants from being candid and, perhaps by virtue of the selection criteria directed towards people who did not engage or benefit, the findings have a predictably negative tone.

Clinical implications

The findings highlight the need for examination of clients' views of the problem and what they deem to be an appropriate solution, as well as effective preparation of client and referrer expectations relating to the process and likely outcome of assisted bibliotherapy. There is a need to minimise the belief that there will be an opportunity to talk at length or that clients will discover the 'root cause' of the problem. Emphasis on self-efficacy and self-management, rather than therapist-directed change, is essential before and during the intervention. As participants were often unclear about the worker's role and the purpose of the intervention prior to the session, some even after the session, it may be naïve to suggest that these issues could be solved solely by GPs giving more detailed information at the point of referral. However, the need for appropriate and accurate information from GPs and workers prior to the intervention is clear.

There are also implications for low-intensity training courses. Participants noted their unease at the apparent youth and inexperience of workers, and informal discussion with several workers in this and other services revealed that while workers were aware of, and in some cases shared their clients' concerns, ways of addressing them were overlooked, or at least not emphasised, during training. Furthermore, it seems that workers, clients and supervisors, rarely raise these

issues. Although this is unsubstantiated anecdotal evidence, these issues appear to be worthy of more explicit attention during training and in supervision.

According to Macleod et al., (2009), the majority of qualified therapists use supplementary self-help materials of some sort, thus the current findings also have implications for more traditional therapeutic settings. Careful consideration of how booklets are introduced may affect subsequent use and value, and could also influence the therapeutic relationship or the credibility of the therapist. Similarly, in the context of increasing emphasis on monitoring of clinical outcomes, the research highlights the importance of ensuring that service users understand the purpose and relevance of questionnaires, and ensuring that they do not dominate or lead to irreparable cracks in the therapeutic alliance.

Recommendations for future research

The study highlights a number of potential areas for future research. It appeared that participants' view of the problem and the solution did not map on to what was being offered. The development of a brief screening measure assessing suitability for this intervention, akin to Gega, Kenright, Mataix-Cols, Cameron and Marks (2005), may be a worthwhile line of inquiry.

A valuable direction for research that could illuminate ways of addressing problems with disengagement might be to consider workers' views and experiences (e.g., whether workers' perceptions of themselves and the intervention correlate with clients' perceptions; accuracy of workers' predictions of clients' perceptions; and whether these factors are associated with outcome). As perceptions of age and inexperience appeared to be an influential factor, investigation into their influence on therapeutic relationship and outcome may be valuable (e.g., comparing service users' perceptions of older and younger workers with differing levels of experience). Similarly, as clinical psychology trainees are often a similar age to workers, consideration of these issues within this arena would be worthwhile, as would further investigation into how such issues are dealt with by supervisors.

Given its positive effect on outcome (Martin, Garske & Davis, 2000), future research into therapeutic alliance in minimal interventions would be worth pursuing. Individual variables associated with the development of a strong alliance and in-session factors that influence its development would be of particular interest, following on from Horvath and Luborsky (1993) and Newman, Erickson, Przeworski & Dzus (2003).

The views of people from minority ethnic groups could also be a focus of future research, as they were under-represented here, and alternative reasons for disengagement or lack of benefit may be revealed. The influence of other dependent variables such as gender, duration of the problem, whether the person has sought professional help previously and what type of help was offered would also be interesting to consider in more detail.

Finally, the experiences and views of those who engaged (i.e., attended all available sessions), or had a good therapeutic alliance but did not gain benefit, were not fully explored here. Hearing their views, as initially planned, remains an interesting area for future research.

Conclusions

Overall, the findings of this study suggest that discrepancy between expectations and experience of minimal interventions, and failure to develop a sufficiently strong therapeutic alliance, contribute to disengagement and lack of benefit. Successful implementation of text-based guided self-help depends, in part, upon clients believing that the 'solution fits the problem', and provision of information at point of referral that emphasises the core features of the intervention and how it differs from traditional psychological therapy. It also depends upon appropriately balancing the needs of the client and the need to follow strict protocol, and addressing ruptures in the therapeutic alliance arising from this. Areas of future research proposed here may shed light on how these issues can be dealt with effectively.

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Part 3: Critical Appraisal

Introduction

This critical appraisal first considers the background to the research and choice of methodology, and follows with a consideration of the theoretical position taken and initial assumptions about what might be found. It then discusses conceptual issues, pragmatic choices and methodological limitations encountered throughout the process, before concluding with some reflections on the impact of the research on the participants and researcher.

Background

I chose to conduct research into guided self-help for several reasons. I first developed an interest in self-help materials prior to training while working as a research assistant in a specialist anxiety disorders clinic. I was impressed with research conducted by colleagues indicating that equivalent reduction in clinical symptoms could be achieved with significantly fewer sessions when using accompanying reading materials (Clark et al., 1999). While I worked at the clinic, I was also fortunate to co-author research on patients' experiences and perceptions of past and present treatments (Stobie, Taylor, Quigley, Ewing & Salkovskis, 2007) and dissemination of CBT in primary care (Grey, Salkovskis, Quigley, Clark & Ehlers, 2008), which is where my interest in these areas originated.

Following this, my initial training placement was in a primary care psychology service where the emphasis was on brief treatment, and I found that using hand-outs and booklets to supplement therapeutic work was an effective way to gain momentum. However, some clients reported not being interested in reading them, which made me curious about the conditions under which such materials would be used and considered valuable. At the time, the Increasing Access to Psychological Therapies (IAPT) programme was being introduced into the service. Initially, I could 'see no wrong' with IAPT, as my knowledge of it thus far was based on enthusiastic conversations with a former supervisor who had played an important role in developing the initiative, and it seemed to me like an incredible opportunity

for the profession and for those in need of services. However, I became increasingly aware of alternative views and dissenting voices, as I worked with psychologists who saw IAPT as a dilution of psychological therapy, or a divisive tool with undue weight placed on returning to work rather than reducing distress; a reaction which intrigued me. Therefore, when an opportunity arose to do research into guided self-help in a different service I was eager to take it, as I thought that my curiosity and previous experience would be valuable assets to draw on.

Choosing a qualitative approach

My previous research employed quantitative methods and I wanted to gain experience of conducting research using a less familiar approach. When initially consulting the literature to generate ideas for a research proposal, I found that research into patients' experiences of guided self-help predominantly featured accounts of those who had completed the intervention and benefitted, or at least reported a positive experience. Consequently, I wanted to find out more about the perspective of those who had *not* engaged or benefitted. Semi-structured interviews seemed to be the best way to gather rich and detailed information about experiences, opinions and perceptions, thus addressing the research questions that were beginning to take shape. My aim was to explore overall experiences and attitudes, rather than consider how those ideas were developed or expressed. Given the clear guidance but relative freedom of application compared to approaches such as interpretive phenomenological analysis (Smith & Osborn, 2003), the transcripts were analysed in accordance with thematic analysis, as outlined by Braun and Clarke (2006).

Position of the researcher and prior assumptions

Guidelines for qualitative research encourage reflection on and declaration of one's personal and epistemological position (Willig, 2008). By reflecting on beliefs and assumptions about the area under review as well as the approach to data

collection and analysis, the influence of these factors can be acknowledged and taken into account by producers and consumers of research.

I adopted an 'essentialist' or 'realist' position (Willig, 2008) for data collection, as I assumed that people's accounts would be a relatively good reflection of their experience and opinions. However, I adopted a more critical approach for data analysis, as I took the view that my interpretation of the accounts would inevitably be subjective, and that themes would be 'constructed' from rather than 'found' in the data.

My personal and professional experience of using reading materials has led me to see them as a valuable resource when life is hard to manage, so at the start of the research process, I assumed that they would be viewed positively. In my eyes, they can be an effective way of helping people to understand and manage their difficulties at a time and place that is convenient for them, in a way that is less 'exposing' than talking with friends, family or professionals, and I thought that others would generally think the same.

However, I also wondered if people might be disconcerted by workers' age and perceived lack of professional and life experience, as these were common concerns for trainees in my year at the start of the course. Most workers employed in these services are graduates in their twenties hoping to gain experience prior to applying for clinical psychology training, and I thought that this would be a likely concern shared by them and their clients.

Portrayals of long-term therapy are relatively commonplace in the media, but there is a distinct absence of portrayals of brief interventions. In my clinical experience, I have found that people often attend for therapy with vague expectations of process and outcome, so it was not a surprise to hear that people had inadequate or inaccurate expectations about what they were actually being offered in this service. However, as the research process took place over a prolonged period and the process of reflection has intensified now that the research

has concluded, I feel somewhat unclear about whether I was expecting this outcome or whether I was simply 'not surprised' when it came through in the accounts. I think that this raises an interesting dilemma about reflecting on and reporting 'prior assumptions' once research has been conducted, and will lead me to record my reflections in more detail earlier in the process when conducting future research.

When engaging in research, it is virtually impossible to have no ideas whatsoever about what might be found. However, it is important to try as much as possible to 'bracket' these ideas (Gibbs, 2007), or put them to one side, and be receptive to all aspects of participants' reports regardless of whether they support or contradict these ideas. During the process of the research, I tried to avoid being driven by my 'hypotheses', and instead be led by the responses of the participants. Although, some of the generated themes were in line with my prior assumptions, I believe that this was because my standpoint had a valid basis, rather than because I sought or focused exclusively on reports that reinforced these views.

Preparation for recruitment and interviewing

I thought that it would be helpful to get an understanding of what people would experience, and so I observed an initial session and obtained copies of the booklets used. When developing the interview schedule and recruitment documentation, I consulted relevant literature but attempted not to be overly influenced by particular theories or prior research. I also tried to ensure that while questions were derived from my initial ideas and assumptions about what might be important, they were sufficiently open-ended to allow participants' accounts to be guided more by their experience than by the nature of the questions asked. I also sought feedback from my supervisors, the service user consultation group and Primary Care Mental Health Workers (PCMHWs) about the relevance of topics and sensitivity of the wording. This preparation enabled me to feel relatively confident that the purpose of the research would be understood, interviewees would find the process appropriate and research questions would be addressed.

As acting service director, my external supervisor's assistance in accessing the sample and gathering support for the project was invaluable. Information was disseminated to PCMHWs via a series of emails and face-to-face meetings. My impression was that it was positively received, as workers indicated that they thought that this would be an interesting and relevant study. However, despite this, and substantial numbers accessing the service, initial identification of potential participants by workers was slower than anticipated. This may have been a result of the perceived time and effort required to identify people, or reluctance to nominate due to apprehension about possible negative evaluations. Following discussion about how to make identification simpler, I was given access to an anonymised version of the database so that I could identify those who may be eligible, with two designated workers, who received extra information about the study and on-going support, doing fine-tuned eligibility and risk assessments. Recruitment would probably have been quicker and easier had I been based within the service, so that the research was continually promoted; however, this would have precluded me from stating my independence from the service and, therefore, would not have been a preferable option.

Reflections on the process of interviewing

On the recruitment documentation I was open about being a trainee clinical psychologist within the NHS; however, once participants made contact I introduced myself as a researcher from UCL. I anticipated that people would, at some stage, be critical of their experience of this NHS service and wondered whether they would feel less able express the full extent of their views if they considered my status as member of the NHS to compromise my impartiality. I tried to project a neutral position, and avoided offering an opinion either way on booklets, workers, forms or guided self-help more generally. When asked why I was doing the research, I simply said that there was evidence to say that it can be effective, but we do not really know much about why it does not seem to work for some people, or why they do not

continue with all the sessions, so the purpose of the interviews was to find out more. I think that this gave a relevant context but it is possible that it may have led people to think that the interview was only focusing on negative experiences. I suspect that this had only a limited influence, as during the interview participants were explicitly asked about positive experiences (e.g., what they found helpful), which would counteract this effect.

With regard to interviewing style, I tried to adopt a curious stance, and made various adaptations as necessary over the course of the interviews. I encouraged participants to elaborate when their answers were brief. Sometimes it seemed like participants presumed that I understood why something was particularly relevant to them, so I began to prompt them prior to commencing interviews to give examples to demonstrate their points. I also clarified that I would continually encourage them to give as much detail as they could, as I wanted to ensure that sufficient detail was given to minimise the risk of their views being inaccurately represented. As is good practice with this approach, I repeatedly summarised and sought clarification on my understanding, but it seemed when reviewing transcripts that some of my questioning appeared to veer towards being leading (e.g., "...so was there anything else that prompted you not to go back, or was it mainly that you didn't feel that whole experience was targeted around you and the problem that you were having at that time?"). On closer inspection of the context, I was phrasing questions in a way that restated what participants had already been said, and so 'leading' statements and questions were generally in the context of previous responses. However, as with much in qualitative research, this is a matter of interpretation. Although I would try to avoid this in future, overall, I was confident that participants felt able to correct me when I had misunderstood – indeed, they did – and that they were free to give an account of their experience that rang true for them.

I also noticed that the content of the exchanges closely resembled that of a therapeutic conversation at times (i.e., exploration of the problem and coping

strategies), and I became aware that my style would occasionally switch from research interviewing to clinical interviewing. I tried to be mindful of this as a potential confound and draw the focus back to the interview schedule when I noticed that this was becoming an issue. Conducting practice interviews may have been a good way to highlight this issue before actual interviews took place.

In line with the iterative process of qualitative research, additional areas of interest were incorporated into the interview schedule as they emerged from preceding interviews (e.g., role of friends and family as support), and I attempted to avoid questions that seemed to overlap. As participants would often spontaneously begin to talk about subjects due to be covered later in the interview, or topics significantly beyond the scope of the research question (e.g., the restructuring of the NHS), it was sometimes difficult to balance the need to maintain the participants' particular focus whilst ensuring that identified topics were covered. I found it helpful to state some broad parameters about the content and process of the interview at the beginning, and indicated that it is common to go 'off-topic' and that if that happened, I would draw the conversation back to the interview schedule to ensure that they would not be kept for longer than had been specified.

The interview schedule was used as a guide rather than a rigid list of inquiries, and questions were formulated as the interview conversation progressed. This had the advantage of making the interaction feel more like a conversation, thus putting participants at their ease and making it more likely that they felt able to speak freely. On reflection, I think that this potentially adversely affected the interviews, as it led to questions occasionally becoming closed. However, questions were posed with numerous options available (e.g., "Would you say that your GP was positive or negative about the service, or..?"), and I indicated hesitancy and uncertainty about potential answers through pauses and non-verbal communication (e.g., shrugging my shoulders). While it is obviously preferable to maintain open-ended questioning, using phrases like "So what impression did you get about the

service from your GP? What do you think they thought about it?" throughout, I struggled to maintain this level of open-endedness continuously.

However, I believe that the overall questioning was sufficiently open to enable participants to give a detailed account of their impressions, and do not believe that they were disproportionately led by me. While efforts were made to improve interview technique with the review of each successive transcript, as the interviews took place while the transcription process was on-going, a simultaneous comprehensive review of style was not possible. When conducting future research, I will keep these experiences in mind and make every effort to review recordings and transcripts more closely prior to subsequent interviews to assess issues with interview technique.

In hindsight, a key question for the 'did not engage' group is why they did not come back. Although this was intended to be addressed explicitly in the interviews it was perhaps only considered implicitly. There were explicit questions about experiences, but reasons why people did not return were addressed much more implicitly. Although Stiles (1993) recommends avoiding 'why' questions, it would nonetheless have been worth probing this issue more directly.

Conceptualisation of groups

Initially, I had planned to compare and contrast the views of two distinct groups: people who did not return after the initial assessment (did not engage) and people who did not demonstrate reliable clinical improvement on outcome measures despite attending all of the available sessions (did not benefit). However, the 'did not benefit' group were harder to recruit than anticipated and only two people came forward. Perhaps those who did not volunteer did experience some benefit which was obscured by the scores and so did not consider themselves eligible. Equally, they could have been fully aware of the lack of benefit, but were not particularly motivated to talk about it (whether they attributed it to the problem, themselves, the intervention, or any other reason).

It is worth considering whether the two people in the 'did not benefit' group are characteristic of others who might fit into this group. P2 emailed his views, as he did not wish to be interviewed and, therefore, his account was much briefer than those of the interviewed participants. P10 had one face-to-face assessment session and several telephone contacts, but was referred to another service around session three and the guided self-help contact continued in the form of updates on how things were going with the other service. Consequently, it was not really possible to get a clear sense of the experiences of the 'did not benefit' group or elaborate on the differences between this and the 'did not engage' group. Future research conducted over a longer timescale, or highlighting at assessment that some service users will be contacted at a later point to get feedback about their experience, may enhance the likelihood of recruiting sufficient numbers.

Further to this point, there was also limited take up in the 'did not engage' group. The pressure to 'get something' came to the fore, and the inclusion criteria were relaxed to include people who did not neatly fit into either group. Several people who had had two or three sessions showed an interest in sharing their views and I thought that the insights to be gained from these interviews were worth pursuing. I conceptualised these participants as 'did not engage' because they could have had further sessions, but chose not to return for similar reasons to those who attended only one session. This conceptualisation is not clear-cut, and I concede that this is my interpretation, which may not be shared by others.

As responses in both groups overlapped significantly and there were insufficient numbers in the 'did not benefit' group for this group to be considered in its own right, themes generated during analysis were presented together. It could be argued that combining the views of the 'did not engage' and 'did not benefit' groups leaves an unclear focus. They are likely to be quite different groups and were conceptualised as such in the planning. However, the differences were not captured in detail here, and there were more similarities than differences in the accounts.

Despite there being no precedent in the literature to consider the distinct groups, attempting to outline differences that may exist between these groups is a valid and interesting avenue for future research.

Analysis and interpretation of the results

In relation to the process of analysis, the data were coded without attempting to map them to an existing theoretical framework, and each data item was given equal attention in the coding process. Themes were based on recurrence in the data, rather than isolated vivid examples, and were generated predominantly at a semantic level (Boyatzis, 1998), where explicit and surface level meaning is the focus and interpretation of their significance and implications follows (Patton, 2002).

Overall, the accounts were more negative than positive, as might be expected, but despite this, there was a consistent recognition from participants that this was 'just their view' and that the service still had value. Even participants who expressed deep disappointment or annoyance offered positive or constructive comments. When considering the themes, I wondered whether aspects of the interviewing or reporting privileged negative experiences over other aspects of patients' experience, as the practical reasons for not attending further sessions that featured in the responses of the non-participants did not appear in the accounts of the interviewed group. I think that there are several valid and plausible reasons that could account for this. The non-participants did not wish to be interviewed and perhaps the reasons that contributed to not attending an interview were similar to those related to not continuing with sessions (i.e., practical obstacles, the problem got better, I found other ways of dealing with the problem, etc.) Similarly, all of the interviewees had the time to attend; they were students, on maternity or sick leave, unemployed or had flexibility in their job, which accounts for the lack of practical obstacles identified.

In relation to the mainly negative responses, I think that such comments are to be expected given the nature of the groups under scrutiny. Disengagement and

lack of benefit carry a degree of inherent negativity, for example, association with 'failure', 'inadequacy', 'disappointment'. Perhaps the recruitment documentation indicated that I was more interested in hearing from people with 'bad' experiences than those with 'good' experiences. Another factor is self-selecting bias; the people who took the time to be interviewed are perhaps the ones with the strongest views and perhaps those with more neutral or positive views were not sufficiently motivated to offer their opinion. Obviously, not everyone who attended this service will hold these views; however, some will inevitably hold weaker versions of these views and so extreme views are still worth consideration.

Personal reflections on the impact of the interview on participants and on me

Over the course of the process, my knowledge and understanding of qualitative methods and philosophies has increased significantly. However, I continue to grapple with a particular dilemma: when a person is asked to give an opinion, first, there is an implicit assumption that they have an opinion to give, and; second, there is an implicit pressure to give an opinion in response. Consequently, the process of questioning 'creates' opinions by asking about them, and this point is reflected in a comment made by a participant: "this interview is giving it an importance that it doesn't have". This issue is clearly not one that can be resolved easily, and after much head-scratching, I have come to the conclusion that participants did have an opinion that they wanted to share, otherwise they would not have come forward. Indeed, when I asked what had prompted people to participate in the research, participants unanimously reported sharing their views and helping to improve services were the main drivers. Several also commented that they were pleased that the research was taking place because it was a sign that "the NHS was listening".

While a small number found talking about their difficulties upsetting and became tearful, all participants managed to complete the interview. Many participants spontaneously reported that talking through their experience had been

valuable, as it had helped them to gain a meta-perspective on their experiences. In some cases, this led them to feel proud about managing to navigate their way out of adverse circumstances (with or without the assistance of guided self-help); for others, it was a motivator to seek help if life was still difficult.

I was surprised that people responded so strongly to being given the booklets, but despite the criticisms documented here, I plan to continue using supplementary materials in my own practice. The accounts here are those of a small minority who, for various reasons, were not able to benefit from the booklets they were given, and this research did not give voice to the many who have found materials helpful. However, conducting this research has sharpened my awareness of the importance of paying close attention to clients' motivation and ability to use them prior to their introduction, and of being sensitive to the views of clients when introducing questionnaires and outcome measures. It has also reinforced how important it is to engage clients in discussions about available treatment options and their views about them in order to ensure that they are active rather than tokenistic participants in the process of making decisions about their care.

Conclusions

The present study has explored how individuals perceived low-intensity services, but the issues raised are much broader. The conclusions and recommendations from this study are clearly relevant to guided self-help clinicians and GPs, but are equally relevant to *any* clinician who uses written supplementary materials and monitors outcomes using self-report questionnaires. The research highlights the need to pay attention to how these are introduced to clients, and the difficulties involved in striking an appropriate balance between being person- and protocol-focused. It also indicates the importance of taking into account the clients' perspective on the context and severity of the presenting problems at the point of referral and assessment, in order to avoid unnecessary treatment failures that may serve to demoralise clients and interfere with future help-seeking and treatment.

Attention to client and referrer expectations and appropriate supervision could go some way to address the important clinical issues raised in this research.

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Appendices

Appendix 1: Invitation Letter



Dear [insert patient name here]

Experiences of engaging with guided self-help in primary care

You were recently offered guided self-help sessions (appointments/ telephone calls with (insert name), Primary Care Mental Health Worker, and booklets on how to tackle worry and low mood) at your local GP surgery.

This is an invitation to take part in a research study conducted by researchers at University College London about people's experiences of guided self-help services in Islington. The researchers are interested in improving services for people who go to their GP for help with worry or low mood, like you did, and we believe that hearing about your experience of the service that you were offered could help us to do that.

Enclosed is a leaflet which provides you with further information about the study. If you are unclear about whether this applies to you, the researcher, Alexandra Quigley, will be happy to discuss this further. Her contact details are on the back of the leaflet.

Alexandra is specifically interested in hearing from you if you did not go back for further sessions after their initial appointment with the mental health worker, or attended all of the sessions that you were offered, but the sessions did not seem to help.

The interview will focus on what influences people's decision to attend or not attend, and how relevant the guided self-help was to the difficulties that people seeking help for. She is interested in what could have been done differently, what could have made your experience better or targeted the problems more effectively. We hope this information will be helpful in improving guided self-help services in the future.

Taking part in the study would involve **an informal one-to-one interview** with Alexandra to discuss your experiences. She is independent from your surgery and the guided self-help service, and participation in this research is entirely voluntary.

If you **are** interested in taking part, please complete the reply slip enclosed and return in the freepost envelope provided. Once your completed slip has been received, Alexandra will contact you to arrange a convenient time to talk to you.

If you **are not** interested in taking part, please complete the reply slip and return it in the freepost envelope provided, as your responses are also important and will still be helpful to us. If you have any questions about taking part do please get in touch with Alexandra.

Thank you for taking the time to consider this invitation.

Yours sincerely,

[Redacted signature]

Service Manager, Islington Primary Care Mental Health Service

For further information, please contact Alexandra Quigley on 07505 604968 or alexandra.quigley@nhs.net

Appendix 2: Participant Information Leaflet

How will the results of the study be used?

General findings will be written up as part of a doctoral thesis and published in a professional publication. I may quote some of your comments, but at no stage will anyone know that it was **you** who told me those things.

Will what I say be confidential?

Your details will be made anonymous (i.e. you will not be identifiable by anyone other than myself). Recordings will be erased after transcription. Transcriptions will be kept securely for five years after publication and will then be destroyed, according to standard research guidelines.



Interested?

If you are interested, you can contact me directly on the details below:

alexandra.quigley@nhs.net

07505 604968

I will then contact you to answer any questions you may have about the study. If you want to participate we can then arrange a time for the interview.

Thank you very much for taking the time to read this leaflet.



Comments, compliments and complaints...

Were you referred to guided self-help sessions by your GP?

- Did you attend your first appointment but didn't go back?
- Did you attend all sessions, but they didn't help?



1 hour interview- we want to hear from you!



What is this research about?

This research aims to understand people's experiences of guided self help to find out:

- why some people decide not to continue with the sessions
- why some of the people who do attend the sessions do not seem to benefit from them

What is the purpose of the study?

The purpose of the study is to make the guided self-help sessions and booklets more appealing and effective.



The study is part of a doctoral degree in Clinical Psychology at University College London (UCL).

Who is doing the research?

The research is being done by Alexandra Quigley, who is a Trainee Clinical Psychologist in the NHS and a student at UCL. Dr Chris Barker (a senior researcher at UCL) and Dr [REDACTED] (a Consultant Clinical Psychologist in the NHS), are supervising the project.

Why have I been chosen?

You have been approached because you have recently been offered guided self help sessions. We are interested in hearing from people who did not want to go back for further sessions after their initial appointment, or who attended all of the sessions that they were offered, but the sessions did not seem to help.

Do I have to take part?

You do not have to take part, if you do not want to. Your decision will have no effect on your current or future treatment.

If you do agree to take part and then change your mind at any point, you may withdraw from the study without needing to give reason.

What will happen if I take part?

If you agree to take part, you will:

- be interviewed for around an hour (at your GP surgery or at University College London) at a time that is convenient for you
- be paid £10 to thank you for your time



The interview will be recorded and later typed up. The researcher will look at your answers in order to understand how the guided self-help service could be improved. It is your chance to talk about your own experiences- it's not a test.

Do you work for the GP surgery?

I do not work for the GP surgery. I am totally independent from your surgery and will not repeat what you tell me to your GP, the guided self-help worker or anyone who works at the surgery.

Appendix 3: Reply slip



PARTICIPANT REPLY FORM

Experiences of engaging with guided self-help

Please complete the following information and return the form in the envelope provided (no stamp required).

A) I AM INTERESTED IN HEARING MORE ABOUT THE STUDY

Please fill in your name and the contact details that you feel happy to give

Name	Home Telephone
Address	Work Telephone
	Mobile
	Email
Preferred contact times/ days	

OR...

B) I AM NOT INTERESTED IN TAKING PART

1. Name (optional): _____
2. Please circle a) or b) as appropriate:
a) I attended most/ all of the appointments that I was offered
b) I attended the first appointment only
3. Please circle **any** of the statements below that apply to you:
(you can circle more than one if you wish)

After the session/ s...

1. The problem seemed more manageable
2. I wanted to see someone more experienced/ qualified
3. The problem had gone completely
4. I found other ways to deal with the problem
5. My GP did not seem enthusiastic about guided self-help
6. I was referred to a different service
7. I could not attend the appointment
8. The problem had become worse
9. I wanted to see someone for regular therapy sessions
10. I did not think that I could be helped by guided self-help booklets
11. Other (please make any additional comment if you wish):

THANK YOU FOR YOUR ASSISTANCE. IF YOU WISH TO DISCUSS ANYTHING, PLEASE CONTACT ME USING THE INFORMATION BELOW:

Alexandra Quigley (Trainee Clinical Psychologist) Department of Clinical, Educational and Health Psychology,
University College London, Gower Street, London, WC1E 6HB alexandra.quigley@nhs.net 07505 604968

Appendix 4: Participant Information Sheet



Participant Information Sheet

Title of Research Project

Experiences of engaging with guided self-help in primary care

Invitation

I am a researcher at University College London and would like to invite you to take part in a research study about people's experiences of guided self-help services in Islington. Before you decide whether to take part, it would be helpful for you to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and decide whether or not you wish to take part. Talk to others about the study if you wish and please ask me if there is anything that is not clear or if you would like more information.

Introduction

A large number of people suffer from problems such as 'worry' and 'low mood', and many people receive help from their local health centres or GP surgeries. Recently, 'guided self-help' (appointments/ telephone calls with a mental health worker and booklets on how to tackle worry and low mood) has been introduced in surgeries as a way of helping people with these problems. It seems that for some people, guided self-help makes a difference, but for others guided self-help does not seem to fit with what they think will help them or additional treatments are required.

What is the purpose of the study?

I am interested in what people who have been referred to or used guided self-help services thought about the service that they received and how it was delivered. We are looking at what influences people's decision to attend or not attend and how relevant the guided self-help was to the difficulties that people were seeking help for. We are also interested in what could have been done differently, that could have made their experience better or targeted the problems more effectively. We hope this information will be helpful in improving such services in the future. This study is being carried out as part of my doctoral degree.

Why have I been invited?

You have been invited to take part because you were referred to the guided self-help service in your surgery. We are interested in improving services for people who go to their GP for help with worry or low mood, like you did, and we believe that hearing about your experience of the service that you were offered could help us to do that. We are specifically interested in hearing from you if you did not go back for further sessions after their initial appointment with the mental health worker, or attended all of the sessions that you were offered, but the sessions did not seem to help. If you are unclear about whether this applies to you, I will be happy to discuss this further- my contact details are at the back of the sheet.

Who is carrying out the study?

My name is Alexandra Quigley and I am a Trainee Clinical Psychologist at University College London (and within the NHS). I am currently carrying out this research project as part of my training. My research is being supervised by a senior researcher at University College London and a Consultant Clinical Psychologist in the NHS (Dr Chris Barker and Dr [REDACTED]).

Do I have to take part?

No, taking part is entirely up to you. If you don't want to take part you will not be asked to give a reason for declining to be interviewed. If you decide to take part, you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not cause any problem for you, your doctor or your health worker, and your treatment would not be affected in any way, now or in the future.

If you *are* interested in taking part, I can describe the study in more detail for you and can go through any questions that you may have from this information sheet.

What will happen to me if I take part?

If you take part, I will interview you in a private room for up to 60 minutes. The interviews will take place either in a local GP surgery or University College London. You can decide which location is most convenient for you. Before the interview begins, I will ask you to sign a consent form to say that you have read the information sheet and are aware of what is involved. You will get to keep a copy of this form. The interview will be informal and the questions are designed to let you talk freely about your experiences of guided self-help. I will record the interview using a digital recorder and will take some notes. As a professional working in the NHS, I have a duty to inform other professionals (such as your GP) if you tell me something during the interview that indicates that you or someone else is currently at risk of harm. I do this to work out how best to make sure you or anyone else you are concerned about are safe, and I will keep you informed of who I speak to and what I tell them if this situation arises.

Expenses and payments

You will receive £10 in cash to cover the costs of attending the interview.

What are the possible disadvantages and risks of taking part?

Interviews are a common way of finding out about people's experiences, and do not have any known risks. This study does not involve our taking any samples or specimens from you. It does not involve your taking any new medications or changing your treatment in any way. You will need to give up 60 minutes of your time and travel to one of the interview venues to take part in the study (a local GP surgery or UCL, near Goodge Street tube station). We will make every effort to arrange the interview at a time convenient to you. You can reschedule or cancel the interview at any time. I will ask you very briefly about the difficulties that you were referred to the guided self-help sessions for, but I do not anticipate that the questions will be upsetting or distressing. In the unlikely event that you feel distressed during the interview, you are free to stop at any time.

What are the possible benefits of taking part?

This interview will give you a chance to let your opinions on guided self-help be known. Guided self-help is fairly new and your opinion is important in influencing the way it is delivered in the future. You may also find it helpful for you to have an opportunity to discuss the difficulties that you were experiencing, and think about the help that you were offered.

What will happen if I don't want to carry on with the study?

You can withdraw from the research at any time and without giving a reason. Any information that we have taken from you will be destroyed and no record will be kept. Withdrawing from the study will not affect the standard of care you receive.

What if there is a problem?

If you have a concern about any aspect of this study, you can speak to me and I will do my best answer your questions (Alexandra Quigley: 07505 604968, alexandra.quigley@nhs.net). If you

remain unhappy and wish to complain formally, you can do this by ringing the NHS complaints department for Camden Primary Care Trust on 020 3317 3500.

Will my taking part in the study be kept confidential?

I do not work for your GP surgery and am independent from the guided self-help service. I will not repeat what you tell me to your GP, the guided self-help worker or anyone who works at the surgery. All information which is collected about you during the course of this research will be kept confidential, and your name and identifying details will be removed so that you cannot be recognised. Only the research team (Ms Quigley, Dr Barker and [REDACTED]) will have access to the data. All interview recordings will be erased immediately after they have been transcribed. Transcriptions will be kept securely for five years after publication and will then be destroyed, according to standard research guidelines.

What will happen to the results of the study?

The results of the study will be written up as part of a doctoral thesis. It is hoped that the findings could be used to develop a set of guidelines that will improve patient care. The general findings may also be published in academic journals and internal NHS management reports, and presented at relevant scientific conferences. I may quote things that you tell me, but at no stage will anyone know that it was you who told me those things. I can also send you a brief summary of the findings.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee (REC) to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the North West London REC 2.

You will get to keep a copy of this information sheet and your signed consent form before you take part in the study.

What do I do now?

If you wish to take part, please complete the enclosed form and return it to us in the envelope (no stamp required). The researcher organising the study will then contact you.

Thank you for taking the time to read this and considering taking part in our research. If you have any questions about taking part do please get in touch with us on the contact details below.

Please feel free to discuss this information with your family, friends or GP.

Alexandra Quigley (Trainee Clinical Psychologist)

alexandra.quigley@nhs.net

07505 604968

Department of Clinical, Educational and Health Psychology

University College London

Gower Street

London

WC1E 6HB

Appendix 5: Consent form



Participant Consent Form **Version 2** **Date: 04/08/10**

Please tick all boxes

- ☐ I have read and understood the Participant Information Sheet and have had the opportunity to ask questions.
- ☐ I agree to be interviewed and recorded, and understand that recordings will be deleted when they have been transcribed (transcripts will be kept securely for 5 years).
- ☐ I understand that my participation is voluntary and that I am able to withdraw at any time without my current or future care being affected.
- ☐ I understand that the research forms part of a doctoral project in psychology and that the findings may result in publication.

Name of participant	Date	Signature
<hr/>		

Name of researcher *	Date	Signature
<hr/>		

*researcher will also gain informed consent

Appendix 6: Interview Schedule



**Experiences of engaging with guided self-help in primary care: Interview Schedule
(version 3 08/09/10)**

Date: _____ Participant ID: _____

Preamble: Thank the participant for coming. Go through the PIS/ consent form. Answer any questions I'm going to ask you a few questions about the guided self help sessions that you were offered at your GP surgery. Your answers will be used to help improve the services that are provided in surgeries. This interview should take no longer than 60 minutes, but please tell me if you would like to take a break or stop altogether. If you do not want to answer any of the questions, let me know and we can go to the next one. Are you happy to continue?

M / F Age at interview: _____ Ethnicity : _____ (use NHS codes)

Occupation: _____

Level of education (highest qualification): _____

- Did not take school exams
- GCSE/ O level
- A level/ NVQ
- Degree/ HND
- Masters/ Doctorate degree

Question topic a) b) c) prompting questions where necessary

1. Introduction to the problem

- a) Could you tell me a little bit about the difficulties that you were having and what prompted you to seek help from your GP?
- b) Was this the first time you had sought help for this? (Could you tell me a little about your prior experiences?)
- c) Whose idea was it to seek help?

2. Introduction to guided self help

- a) Could you tell me a little bit about what happened when you went to your GP for help? What did s/he tell you about guided self help? What happened next? (ask about their 'journey' (GP visit/ referral > telephone contact by worker to make appointment > assessment and leaflets given> telephone contact and two follow-up appointments: Is this the path followed by the respondent?)

3. Expectations

- a) When your GP told you about the guided self help offered by the mental health worker, what did you think it would involve?
- b) What were you hoping for?
- c) What were your thoughts or opinions about whether it was right for (would work) you? What made you think that? (prior experience, GP, friends, media, leaflet)

4. Decision about attending

- a) How did you decide about whether or not to attend the first appointment? What influenced your decision?
- b) What prompted you to come to the first appointment?
- c) How did you decide about whether or not to attend the follow-up appointments? What influenced your decision? (*What prompted you to come to the follow-up appointments?*)

- 5. Experience of appointment/ calls**
- a) Can you tell me a little about what you remember about the appointments/ calls? What was your overall experience? What was said? What happened?
 - b) How did it compare to what you were hoping for?
 - c) Was there any moment that you saw as a 'turning point'?

- 6. Therapeutic alliance**
- a) Can you tell me a little about what you thought about the PCMHW? How does it compare to what you were expecting/ hoping for?
 - b) How did you find talking with them about your difficulties? Supportive/ not particularly? Was there anything about them that you were disappointed/ pleased with?
 - c) Did they make you feel like they were 'tuned in' to what you were saying? Did they seem to understand your difficulties?
 - d) Did they seem to know what they were talking about? How credible were they?

- 7. Materials**
- a) What did you think about the materials? Were they relevant? Useful? Appropriate?
 - b) Did they target the problems that you came for help for?
 - c) Did the guided self help result in any noticeable changes in your life?
 - d) Did the rationale seem clear to you? Was it difficult to find the time/ motivation to read the booklets/ to do the activities?

- 8. Opinions about guided self help**
- a) In your view what were the most helpful/ least helpful aspects of guided self help?
 - b) What is your view of guided self help now?
 - c) Would you try guided self help in the future?

- 9. Improvements**
- a) What could the worker have done differently, or additionally, that could have made your experience better? Information before the appointment? Telephone contact? Letters? Materials? Number of appointments? Time of appointments? The manner of the worker?

- 10. Current situation**
- a) Can you tell me a little bit about how things are for you now? Are you still having difficulties? Did you try anything else/ any other service? Can you tell me more about that? Did it help?

11. De- brief

We have come to the end of the interview, and I have just a few more questions. I will be in touch in the next few weeks with a summary of what we have discussed today. I do this to make sure that I have understood what you have said correctly and to check if there is anything further that you would like to add.

- ☐ What would be the best way to contact you?
- ☐ Would you like a summary of general findings at the end of the study?
- ☐ What would be the best way to send that to you? (email/post?)
- ☐ Are there any important questions that you think were missed out?
- ☐ Would you like to ask any questions or make any comments now that the interview is over?
- ☐ If you think of any questions then please get in touch using the details on the consent form. Thank the participant for their time. Give the voucher.

Appendix 7: NHS Ethics Approval Letters



National Research Ethics Service

North West London REC 2

Royal Free Hospital NHS Trust
Royal Free Hospital
South House, Block A
Pond Street
London
NW3 2QG

04 October 2010

Ms Alexandra Quigley
University College London
Department of Clinical Psychology
Gower Street, London
WC1E 6HB

Dear Ms Quigley

Study title: Experiences of engaging with guided self-help in primary care
REC reference: 10/H0720/58
Amendment number: AM01
Amendment date: 10 September 2010

Thank you for your letter of 10 September 2010, notifying the Committee of the above amendment.

The amendment has been considered by the Chair.

The Committee does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

Documents received

The documents received were as follows:

Document	Version	Date
Interview Schedule	3	08 September 2010
Participant Reply Form	2a	18 August 2010
Letter of invitation to participant	3	08 September 2010
Participant Consent Form	2	04 August 2011
Participant Information Sheet	2a	18 August 2010
Notification of a Minor Amendment		10 September 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H0720/50:

Please quote this number on all correspondence

Yours sincerely



Thomas McQuillan
Committee Co-ordinator
E-mail: Thomas.mcquillan@royalfree.nhs.uk

Copy to:

Mr David Wilson

Appendix 8: NHS and UCL R&D Approval Letters



**North Central London
Research Consortium**

Research Operations Unit
3rd Floor West Wing
St Pancras Hospital
4 St Pancras Way
London
NW1 0PE

General Enquiries: 020 3317 3756
Office Fax: 020 3317 3760

29th October 2010

Ms Alexandra Quigley
University College London
Department of Clinical Psychology
Gower Street
London
WC1E 6HB

Dear Ms Quigley,

Title: Experiences of engaging with guided self-help in primary care

LREC Ref: 10/H0720/58

I am pleased to confirm that the above study has now received R&D approval, and you may now start your research in **Islington NHS PCT**. May I take this opportunity to remind you that during the course of your research you will be expected to ensure the following:

- **Patient contact:** only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust's patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998.
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Adverse events:** adverse events or suspected misconduct should be reported to the R&D office and the Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications:** it is essential that you inform the R&D office about any publications which result from your research.
- **Ethics:** R&D approval is based on the conditions set out in the favourable opinion letter from the Ethics Committee. If during the lifetime of your research project, you wish to make a revision or amendment to your original submission, please contact both the Ethics Committee and R&D Office as soon as possible.

NoCLoR R&D Approval Letter 17.03.06

Please ensure that all members of the research team are aware of their responsibilities as researchers. For more details on these responsibilities, please check the R&D handbook or NoCLoR website:
<http://www.noclor.nhs.uk>

We would like to wish you every success with your project

Yours sincerely,

A handwritten signature in purple ink, appearing to read 'Angela Williams', followed by a horizontal line.

Mrs Angela Williams
R&D Manager



University College London Hospitals



NHS Foundation Trust

Joint UCLH/UCL Biomedical Research (R&D) Unit

Office Location:

1st Floor, Maple House
149 Tottenham Court Road
London W1T 7DN

Postal Address:

Rosenheim Wing, Ground Floor
25 Grafton Way.
London WC1E 5DB

Email: david.wilson@ucl.ac.uk Tel: 0845 1555 000 Ext. 5199 Fax: No 020 7380 9937
Web-site: <http://www.ucl.ac.uk/joint-rd-unit>

20th April 2010

Mr Alexandra Quigley
Research Department of Clinical, Educational and
Health Psychology
UCL
1-19 Torrington Place
London
WC1E 6BT

Dear Mr Quigley,

Chief Investigator: Mr Alexandra Quigley
Study/Trial Title: D Clin Psy Project: Experiences of engaging with guided self help in primary care
Funder: Departmental
Sponsor's Project ID No: 10/0126

Re: UCL study/trial insurance.

With respect to the above trial, I am pleased to inform you that the above referenced study/trial, as detailed in your UCL Insurance Registration Form of 8th April 2010, has been included on the register for UCL's insurer's Clinical Trials Policy, which provides appropriate insurance for harm arising out of the study/trial. The current policy certificate is included within appendix 1 of this letter. This includes insurance for negligence of UCL employees and for non-negligence harm.

Employees of University College London Hospitals NHS Foundation Trust will be covered by the Clinical Negligence Scheme for NHS Trusts (website available at: <http://www.nhs.uk/Claims/Schemes/CNST/>) under the NHS Litigation Authority liabilities and indemnities arrangements (website available at: <http://www.nhs.uk/home.htm>).

Indemnity and insurance arrangements will be further detailed in the Site Agreements in place for each participating site.



UCL Hospitals is an NHS Foundation Trust incorporating the Eastman Dental Hospital, Elizabeth Garrett Anderson & Obstetric Hospital, The Heart Hospital, Hospital for Tropical Diseases, The National Hospital for Neurology & Neurosurgery, The Royal London Homoeopathic Hospital and University College Hospital.

Insurance Registration Confirmation letter Version 7 dated 15.3.2010

R&D ID 10/0126

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Please keep a copy of this letter for your records. Feel free to contact me if you have any queries concerning the cover.

Yours sincerely,



DAVE WILSON
Database & Information Officer

cc. Prof Chris Barker (UCL Research Department of Clinical, Educational and Health Psychology)



UCL Hospitals is an NHS Foundation Trust incorporating the Eastman Dental Hospital, Elizabeth Garrett Anderson & Obstetric Hospital, The Heart Hospital, Hospital for Tropical Diseases, The National Hospital for Neurology & Neurosurgery, The Royal London Homoeopathic Hospital and University College Hospital.

Insurance Registration Confirmation letter Version 7 dated 15.3.2010

R&D ID 10/0126

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To Whom It May Concern

This is to confirm that University College London and Subsidiary Companies have in force with this Company until the policy expiry on 31/07/10 Insurance incorporating the following essential features:

Policy Number: NHE-01CA06-0023

Limit of Indemnity:

Public Liability:	£	50,000,000	any one event
Products Liability:	£	50,000,000	for all claims in the Pollution: aggregate during any one period of insurance
Employers' Liability:	£	50,000,000	any one event inclusive of costs

Excess :

Public Liability/Products Liability/Pollution:	£ 250 any one event
Employers' Liability:	£ Nil

Indemnity to Principals :

Covers include a standard Indemnity to Principals Clause in respect of contractual obligations.

Zurich Municipal
Zurich House
2 Gladiator Way
Farnborough
Hampshire
GU14 6GB

Telephone 0870 2418050
Direct Phone 01252 387877
Direct Fax 01252 375244
E-mail
claire.purdy@uk.zurich.com

Communications will be monitored
regularly to improve our service and
for security and regulatory purposes

Zurich Municipal is a trading name of
Zurich Insurance plc

A public limited company incorporated
in Ireland. Registration No. 13460
Registered Office: Zurich House,
Ballsbridge Park, Dublin 4, Ireland.

UK branch registered in England and
Wales Registration No. BR7985.
UK Branch Head Office: The Zurich
Centre, 3000 Parkway, Whiteley,
Fareham, Hampshire PO15 7JZ

Authorised by the Irish Financial
Regulator and regulated by the Financial
Services Authority for the conduct of UK
business

Clinical Trials	£ 10,000,000	for all claims in the No Fault Compensation:
	aggregate per	
Clinical Trial	£ 12,500,000	for all claims in the aggregate during any one period of insurance

Excess: Per claimant £250

Scope : Legal Liability and No Fault Compensation Scheme

SECTION 1 – Special Definitions

Geographical Limits

- (a) the TERRITORIAL LIMITS
- (b) elsewhere in the world other than the United States of America, Canada and any territory within their jurisdictions

Research Subject

any person participating in a Clinical Trial including their dependants heirs executors administrators and legal representatives

Clinical Trial

- (1) clinical research requiring a clinical trials authorisation under the Medicines for Human Use (Clinical Trials) Regulations 2004 or clinical investigation requiring approval under the Medical Devices Regulations 2002 or
- (2) an investigation or series of investigations conducted on any person for treating or preventing disease, diagnosing disease or ascertaining the existence, degree of or extent of a physiological or psychological condition, inducing anaesthesia or otherwise preventing or interfering with the normal operation of a physiological or psychological function



UCL Hospitals is an NHS Foundation Trust incorporating the Eastman Dental Hospital, Elizabeth Garrett Anderson & Obstetric Hospital, The Heart Hospital, Hospital for Tropical Diseases, The National Hospital for Neurology & Neurosurgery, The Royal London Homoeopathic Hospital and University College Hospital.

Insurance Registration Confirmation letter Version 7 dated 15.3.2010

R&D ID 10/0126

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Principal Exclusions :

The INSURER will not be liable in respect of:

1. Conception, Contraception, Pregnancy and Young Children

- (a) any Clinical Trial in which the medicinal purpose is either assisting with or altering in any way the process of conception, or investigating or participating in methods of contraception
- (b) any Injury to any Research Subject who is known to be pregnant at the time of the Clinical Trial
- (c) any Injury to any Research Subject who is under the age of 5 years at the time of the Clinical Trial

except in respect of Injury arising solely and directly from any of the following:

- (i) the measurement of physiological processes using non-invasive methods
- (ii) administration by mouth of foods or variation of diet other than the administration of drugs or food supplements
- (iv) the collection of bodily secretions and excretions for analysis by non-invasive methods
- (v) the sampling of blood from the antecubital fossa or back of the hand using the venepuncture vacuum system

2. Contracts

the failure of the INSURED to fulfil its obligations under any contract entered into with the Research Subject.

3. Creutzfeldt-Jakob Disease

any claim arising from any condition directly or indirectly caused by or associated with Creutzfeldt-Jakob Disease (CJD) variant Creutzfeldt-Jakob Disease (vCJD) or new variant Creutzfeldt-Jakob Disease

4. Genetic Engineering

any Clinical Trial involving genetic engineering other than a Clinical Trial in which the medicinal purpose is treating preventing or diagnosing disease

5. Hepatitis

any claim arising from Hepatitis or any condition directly or indirectly caused by or associated with Human T-Cell Lymphotropic Virus Type iii (HTLV iii) or Lymphadenopathy Associated Virus (LAV) or the mutants derivatives or variations thereof or in any way related to Acquired Immune Deficiency Syndrome or any syndrome or condition of a similar kind howsoever it may be named

6. Legal liability under agreement

any liability for Injury which attaches solely because of an agreement or contract

7. Substances

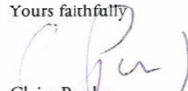
any Clinical Trial where the substance under investigation has been designed, manufactured or modified by the INSURED.

Full Policy:

The policy documents should be referred to for details of full cover.

Yours faithfully

Zurich – 125 years.
Inspired by tomorrow.



Claire Purdy
Underwriting Services
Zurich Municipal
Ref: 1



Garrett Anderson & Obstetric Hospital, The Heart Hospital, Hospital for Tropical Diseases, The National Hospital for Neurology & Neurosurgery, The Royal London Homoeopathic Hospital and University College Hospital.

Insurance Registration Confirmation letter Version 7 dated 15.3.2010

R&D ID 10/0126

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Appendix 9: Analysis – Initial coding

(Submitted to examiners, but omitted here to protect anonymity)

Appendix 10: Analysis – Development of themes and subthemes

(Submitted to examiners, but omitted here to protect anonymity)